Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY8: October 1, 2018 – September 30, 2019
State Fiscal Year FY19: September 1, 2018 – August 31, 2019
Submitted on February 4, 2020

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

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

1. Preface

1.1 Transmittal Title Page

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

2. Executive Summary

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

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

According to the Special Terms and Conditions (STCs) of the Demonstration, the Texas Health and Human Services Commission (HHSC) provides its operational report for Demonstration Year (DY) 8 and State Fiscal Year 2019 (SFY19), from September 1, 2018, through August 31, 2019. This report provides the semiannual reporting requirements for STAR, STAR Kids, STAR+PLUS, and the Children's Medicaid Dental Services (Dental Program). The STCs require the State to report on various topics, including enrollment and disenrollment, network adequacy, benefits, member issues, quality, operations and policy, budget neutrality, evaluation of the demonstration, the Delivery System Reform Incentive Payment Program (DSRIP), and public forums.

During SFY19, the State contracted with 18 managed care organizations (MCOs) and 2 dental maintenance organizations (DMOs): 16 for STAR, 10 for STAR Kids, 5 for STAR+PLUS. Each MCO covers one or more of the 13 STAR service delivery areas (SDAs), while each dental plan provides statewide services (*See **Attachment A***).

HHSC staff evaluate and routinely MCO and DMO performance reported by the MCOs and DMOs and compiled by HHSC. If an MCO or DMO fails to meet a performance expectation, standard, schedule, or other contract requirement such as the timely submission of deliverables or providing the level of quality required, the managed care contract gives HHSC the authority to use a variety of remedies, including:

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

The information reflected in this report represents the most current information available at the time that it was compiled. The sanction process between HHSC and the health and dental plans may not be complete at the time the report is submitted to the Centers for Medicare and Medicaid Services (CMS). HHSC posts the final details of any potential enforcement actions taken against a health or dental plan each quarter on the following website:
https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-sanctions.

3. Enrollment

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

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

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

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

In SFY19, from SFY Q3 to SFY Q4 total enrollment increased in STAR (0.83%), increased in STAR+PLUS (0.08%), and decreased in STAR Kids (-0.24%). The Dental Program had the highest increase (13.80%) in enrollment between Q3 to Q4 (See ***Attachment B1***). The market share distribution (*Mktshare=Total of each Program QTR data/Program Total*) in STAR, STAR Kids, and STAR+PLUS fluctuated 1% or less throughout SFY19. During Q4 the market share for STAR was at 80%, for STAR+PLUS 15%, and STAR Kids 4%. Market share distribution in the Dental Program remained steady as DentaQuest finished the year with 58% and MCNA with 42%.

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

The State's enrollment broker, MAXIMUS, reported unduplicated enrollments for SFY19 Q1 encompassing September 2018, October 2018, November 2018 with effective dates of October 1st, November 1st, December 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,572,496. The Dental Program reported total enrollments for the same time period with an average of 2,836,384. (See ***Attachment L, CMS 3rd Quarter (2018), pg. 4 for September; See Attachment L, March 2019, pg. 4 for October-November***).

Unduplicated enrollments for SFY19 Q2 encompassing December 2019, January 2019, February 2019 with effective dates of January 1st, February 1st, and March 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,530,264. The Dental Program reported total enrollments for the same time period with an average of 2,804,291. (See ***Attachment L, March 2019, pg. 4***).

Unduplicated enrollments for SFY19 Q3 encompassing March 2019, April 2019, May 2019 with effective dates of April 1st, May 1st, June 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,453,376. The Dental Program reported total enrollments for the same time period with an average of 2,733,591. (See ***Attachment L, CMS 2nd Quarter, pg. 4 for April-May; See Attachment L, March 2019, pg. 4 for March***).

Unduplicated enrollments for SFY19 Q4 encompassing June 2019, July 2019, August 2019, with effective dates of July 1st, August 1st, September 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,465,398. The Dental Program reported total enrollments for the same time period with an average of 2,737,706. (See ***Attachment L, CMS 3rd Quarter, pg. 4 for July-August; See Attachment L, CMS 2nd Quarter, pg. 4 for June***).

For SFY19, the average among all four quarters for STAR, STAR+PLUS, and STAR Kids is 3,505,384 and the average among all four quarters for The Dental Program is 2,777,993.

Enrollment Counts for the Quarter by Population

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

Enrollment Counts (DY8 Q1 October – December 2018)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	325,840
Children	2,778,020
Aged and Medicare Related (AMR) (non MRSA - pre Sep14)	381,907
Disabled	423,019

Enrollment Counts (DY8 Q2 January – March 2019)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	325,840
Children	2,755,636
AMR (non-MRSA - pre Sep14)	380,994
Disabled	421,134

Enrollment of Members with Special Health Care Needs

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

In SFY19 Q4, STAR MCOs reported a total of 87,628 children and adults identified as MSHCN (See ***Attachment Q***). Of these, 24.49% of MSHCN have a service plan in SFY19 Q3 and 16.77% had a service plan in Q4. Additionally, for SFY19 Q4 three MCOs reported more than 60% of MSHCN had a service plan (Aetna, Parkland and United Healthcare). Aetna reported more than 75% of MSHCN had a service plan for Bexar (76.79%) and Tarrant (80.37%) SDA. Parkland reported more than 75% of MSHCN had a service plan for Dallas (77.26%) SDA. United Healthcare reported more than 60% of MSHCN had a service plan for Harris (77.67%), Hidalgo (81.08%), Jefferson (75.00%), and Nueces (68.00%) SDAs. For SFY19 Q4 five plans reported less than 10% of MSHCN had a service plan (Amerigroup, Community First, Superior, Texas Children's and Dell) citing "declined service management" and "unable to reach" as reasons why MSHCN did not have a service plan.

Disenrollment

The State received a total of 28 Medicaid disenrollment requests in SFY19 (See ***Attachment B2***). The State received the following in SFY Q4: 1 disenrollment requests for STAR, 2 for STAR+PLUS, zero for STAR Kids and zero for the Dental Program. For all four quarters the state received a total of 16 disenrollment requests for STAR, 12 for STAR+PLUS, zero for STAR Kids and zero for the Dental Program. Most of the requests for SFY19 disenrollment were initiated by members or their representatives.

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***). The Provider Network Count Methodology may be found in ***Attachment C1***.

Across the STAR program statewide, the MCOs reported no significant change in unique PCP providers, between SFY Q3 and SFY Q4. The MCOs reported an increase (1.4%) for the STAR+PLUS program in unique PCP providers, between SFY Q3 and SFY Q4. The MCOs reported a decrease (-0.7%) for the STAR Kids program in unique PCP providers, between SFY Q3 and SFY Q4.

Across the STAR program statewide, the MCOs reported a decrease (-0.7%) in unique specialists, between SFY Q3 and SFY Q4. The MCOs reported an increase (5.8%) for the STAR+PLUS program in unique specialists, between SFY Q3 and SFY Q4. The MCOs reported an increase (0.7%) for the STAR Kids program in unique specialists, between SFY Q3 and SFY Q4. There was no change in the dental program in unique specialists.

Across the STAR population statewide, the MCOs reported a decrease (-0.2%) in unique dental providers, between SFY Q3 and SFY Q4. The MCOs reported an increase (10.0%) for the STAR+PLUS population

in unique dental providers, between SFY Q3 and SFY Q4. The MCOs reported an increase (7.3%) for the STAR Kids program in unique dental providers, between SFY Q3 and SFY Q4.
Across the STAR program statewide, the MCOs reported an increase (0.8%) in unique pharmacists, between SFY Q3 and SFY Q4. The MCOs reported an increase (12.3%) for the STAR+PLUS program in unique pharmacist, between SFY Q3 and SFY Q4. The MCOs reported an increase (1.2%) for the STAR Kids program in unique pharmacist, between SFY Q3 and SFY Q4.

Across the dental program statewide, the DMOs reported an increase (1.7%) in unique primary dental providers between SFY Q3 and SFY Q4.

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY19. The MCOs reported a variety of reasons for provider termination for primary care providers and specialists. The top three reasons for PCP terminations included "provider leaving group practice", "termination requested by provider", and "provider moving". The top three reasons for specialist terminations included "provider leaving group practice", "termination requested by provider", and "provider failing to re-credential".

Network Adequacy

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

Attachment H1 provides PCP network access analysis by program and county type. All MCOs met PCP network access standards for the STAR, STAR+PLUS and STAR Kids programs for SFY19 Q4.

Specialist network access ensures specialty provider access within the distance standard of 90% of two providers for each specialty provider. The specialty providers include behavioral health outpatient; cardiovascular disease; ear, nose and throat (ENT), general surgeon, nursing facility, OB/GYN, ophthalmology, pediatric sub-specialty, prenatal care, therapy (occupational, physical, and speech), psychiatry, and urology.

Attachment H2 (included in Attachment H) displays specialty provider analysis by program and county designation. The following MCOs did not meet all performance standards in SFY19 Q4:

Cardiovascular Disease

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

ENT (otolaryngology)

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

General Surgeon

- STAR
  - Micro - Cook Children's Health Plan.
- STAR Kids
  - Micro - Texas Children's Health Plan.
- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro - Cigna-HealthSpring, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural - Cigna-HealthSpring and Superior HealthPlan.

Nursing Facility

- STAR+PLUS
  - Micro - Superior HealthPlan.
  - Rural - Cigna-HealthSpring, Superior HealthPlan, and UnitedHealthcare Community Plan.

OB/GYN

- STAR
  - Micro - Driscoll Health Plan.
- STAR Kids
  - Micro - Driscoll Health Plan.
- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro - Cigna-HealthSpring and Superior HealthPlan.
  - Rural - Cigna-HealthSpring.

Ophthalmologist

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

  - Micro - Cook Children's Health Plan, Driscoll Health Plan, Superior HealthPlan, and Texas Children's Health Plan.
  - Rural – Amerigroup, Superior HealthPlan, and Texas Children's Health Plan.
- STAR+PLUS
  - Micro - Cigna-HealthSpring, Superior HealthPlan, and UnitedHealthcare Community Plan.
  - Rural - Cigna-HealthSpring and Superior HealthPlan.

Orthopedist

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

Pediatric Sub-specialty

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

Prenatal

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

Therapy (Occupational, Physical, and Speech)

- STAR
  - Rural - FirstCare.
- STAR+PLUS
  - Metro - Cigna-HealthSpring.
  - Micro - Cigna-HealthSpring.

    - Rural - Cigna-HealthSpring.

Psychiatrist

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

Urologist

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

The DMOs (DentaQuest and MCNA) met the network access standard throughout SFY19. ***Attachment H under the page titled H3*** provides dentist analysis by DMO and county designation.

Access to dental specialty providers (endodontist, orthodontist, pediatric dentist, and prosthodontist) was limited in most county types across the state. DMOs met all performance standards for orthodontist and pediatric dentist. For endodontist and prosthodontist dental specialty providers, the DMOs didn't meet the distance standard for any county type. ***Attachment H under the page titled H4*** provides dental specialty analysis by provider type and county designation.

Network Adequacy Standard Exceptions

MCOs and DMOs may submit an exception request for areas of non-compliance. HHSC approves or denies the exception request based on the review of supporting information that demonstrates the MCO provider contracting efforts and assurance of access to care. As part of the exception, the MCO must implement strategies to proactively contact and provide education to the impacted members on how to access care by approaches such as providing a list of network providers in the area, how to access care outside of the area, how to contact member services and the Member Hotline, what to do in case of an emergency, and how to access non-emergent medical transportation and the MCOs' transportation value-added service, if available. The MCO must ensure continuity of care and offer single case agreements with a provider to ensure the member's continued care, as necessary. If the exception request is denied, the MCO is subject to remedies such as liquidated damages or a corrective action plan.

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

Access to Pharmacy

MCOs are required to provide pharmacy access to members in each service delivery area (SDA) within the contractual performance standards. Effective SFY 2019, the performance standards changed as follows:

For counties included in the Medicaid Rural Service Area (MRSA), the following standard applies 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; and
- 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 standard 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; and
- 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.

HHSC has received preliminary data however we are revising our processes to ensure we have the most accurate representation of the provider networks and plan to provide detailed analysis in our next semi-annual report.

Provider Open Panel

MCOs submit provider files identifying the number of PCPs and main dentists who are accepting new Medicaid patients, which are described here as "open panel" PCPs and "open practice" dentists. HHSC monitors PCPs with Open Panel at an 80% benchmark. In SFY19 Q4, all MCOs and DMOs, except Cook Children's in STAR and STAR Kids, met the 80% benchmark at 74% and 73% respectively. However, HHSC has not identified access to care concerns, issues, or complaints. Cook Children's contracts with PCPs that elect to maintain a closed panel. The PCPs provide services to a certain number of Medicaid clients as well as other clients not enrolled in these programs. In addition, Cook Children's has the flexibility of working with certain PCPs who have a closed panel to agree to take on new members normally achieved on a case-by-case basis. This arrangement has allowed Cook Children's to maintain

these providers in the network**.** Based on these justifications, HHSC is not pursuing remedial action against Cook Children's.

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 30% 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 SFY19. The survey results are as follow: STAR program provider compliance was 51% in accessibility and 47% in language, STAR Kids program provider compliance was 76% in accessibility and 77% in language, and STAR+PLUS program provider compliance was 74% in accessibility and 76% 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 ensure compliance with the OON utilization standards. MCOs may submit a Special Exception Request Template (SERT) for areas of non-compliance. HHSC approves or denies the SERT based on the review of supporting information that demonstrates the MCO was unsuccessful in provider contracting efforts. If approved, the MCO submits a recalculated Out-of-Network Utilization Report, excluding the utilization of the aforementioned provider(s). If the recalculation does not bring the MCO into compliance, the MCO remains out of compliance and is subject to contract action such as assessing monetary damages or implementing a corrective action plan. ***Attachment D*** provides OON utilization performance summary.

The MCOs listed below exceeded OON utilization standards in SFY19 Q4. The State will continue to monitor these MCOs and will require corrective action or other remedies if appropriate.

<u>OON Emergency Room (ER)</u>

- STAR
  - Aetna: Bexar SDA
  - Community First: Bexar SDA
  - Dell Children's: Travis SDA
  - Molina: Dallas and Harris SDAs
  - Texas Children's: Harris SDA
- STAR+PLUS
  - Molina: Dallas SDA
- STAR Kids
  - Children's Medical Center: Dallas SDA
  - Texas Children's: Harris SDA

<u>OON Inpatient</u>

- STAR
  - Aetna: Bexar SDA
  - Molina: Dallas, Harris and Jefferson SDAs
- STAR+PLUS
  - Molina: Dallas and Harris SDAs
- STAR Kids
  - Blue Cross Blue Shield: MRSA Central SDA

<u>OON Other and Outpatient</u>

- STAR
  - Aetna: Tarrant SDA
  - Community First: Bexar SDA

- Molina: Jefferson SDA

- STAR+PLUS
  - Amerigroup: Jefferson SDA
  - Cigna-HealthSpring: MRSA Northeast and Tarrant SDA

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

OON Emergency Room (ER)

- STAR
  - Aetna: Bexar SDA
  - Dell Children's: Travis SDA
  - Molina: Dallas and Harris SDAs
  - Texas Children's: Harris SDA

- STAR+PLUS
  - Molina: Dallas SDA

- STAR Kids
  - Children's Medical Center (Dallas SDA)

OON Inpatient

- STAR
  - Molina: Dallas, Harris and Jefferson SDAs

- STAR+PLUS
  - Cigna HealthSpring: MRSA Northeast, and Tarrant SDAs
  - Molina: Dallas and Harris SDAs

- STAR Kids
  - Blue Cross Blue Shield: MRSA Central SDA

OON Other and Outpatient

- STAR
  - Molina: Jefferson SDA

- STAR+PLUS
  - Amerigroup: Jefferson SDA
  - Cigna-HealthSpring: MRSA Northeast and Tarrant SDAs)

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

3.1 Enrollment Issues/Trends: New and Continued

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

3.2 Anticipated Changes to Enrollment

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

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

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

4. Benefits

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

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

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

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

☐ (Required) The state has attached completed the benefit metrics in Appendix X.

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

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

Service Utilization

Attachment S illustrates enrollment and expenditures by program and claim type for SFY18, covering September 1, 2017 through August 31, 2018. The total spending in STAR, STAR+PLUS, and STAR Kids in SFY18 inlcuded:

- Professional claims: 36.63%
- Outpatient claims: 23.07%
- Drug claims: 17.47%
- Inpatient claims:17.22%

- Dental Claims: 5.61%

"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.

Medicaid Managed Care

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

The Texas Legislature directed a change in the approach for the transition of long-term services and supports (LTSS) from a fee-for-service model to a managed care model through House Bill (HB) 4533, 86th Legislature, Regular Session, 2019. HB 4533 amends Government Code Chapter 534 and outlines two stages for implementation. Stage one directs a pilot program through the STAR+PLUS Medicaid managed care program to test person-centered managed care strategies and improvements based on capitation. Stage two delays and staggers the carve-in of waivers and community intermediate care facilities programs to a Medicaid managed care model, or system redesign, beginning with Texas Home Living in 2027.

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

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

Compliance with Home- and Community-Based Services Settings Regulations

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

Medicaid

Tobacco Cessation Counseling

Smoking and tobacco use cessation counseling benefits are no longer restricted to women with a diagnosis of pregnancy-related complications due to tobacco use. Effective May 1, 2019, procedure codes 99406 and 99407 are benefits for Medicaid recipients ages 10 and older with any nicotine dependence related diagnosis. Effective July 1, 2019, modifier HQ (indicating group services) was added to procedure codes 99406 and 99407 to allow delivery of smoking cessation counseling in groups of up to eight clients.

School-based Telehealth Services

The Texas Legislature required Medicaid reimbursement for school-based telehealth (non-physician delivered) services through Senate Bill 922, 85th Legislature, Regular Session, 2017. Effective August 1, 2019, telehealth occupational and speech therapy services are a benefit to children in school-based settings. All occupational and speech therapy services chosen for reimbursement when remotely delivered were already a benefit when delivered in-person. School-based settings are defined in the legislation as “school district” or “open-enrollment charter school campuses”.

Mobility Aids

Effective August 1, 2019, overhead and fixed client lifts were added to the mobility aids policy for clients 20 years of age or younger. Documentation to support the medical necessity for these specialized client lifts is outlined in the mobility aids policy.

Future Amendments

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

House Bill 72 requires HHSC to allow children receiving Supplemental Security Income (SSI) or who were receiving Supplemental Security Income before becoming eligible for Adoption Assistance (AA) or Permanency Care Assistance to continue to receive services under STAR Health or STAR Kids. The bill directs HHSC to protect the continuity of care for each child described in the bill and, if applicable,

ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

HHSC will be submitting an amendment to the 1115 waiver to add non-emergency medical transportation services to STAR, STAR+PLUS, and STAR Kids. HB 1576, 86th Legislative Session, makes the following changes to Medicaid non-emergency medical transportation: Increases opportunities for transportation network companies (TNCs) to deliver NEMT in addition to more traditional transportation providers. Requires MCOs to provide non-medical transportation services, a subset of demand response transportation services, for certain trips requested with less than a 48-hour notice. Moves the responsibility to provide all NEMT services for Medicaid managed care members from managed transportation organizations (MTOs) to managed care organizations (MCOs). HHSC is working to implement this legislation.

5. Demonstration-related Appeals

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

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

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

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

☐ (Required) The state has attached completed the appeals metrics in Appendix X.

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

Complaints and Appeals Received by MCOs

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

Attachment N1, N2, and N3 provides complaints and appeals performance summary. Data discussed in the narrative are based on the most recent data available, which is the final month of Q2.

The total number of STAR complaints and appeals received by plans increased from 2,699 in 2019 SFYQ3 to 2,976 in 2019 SFY Q4. STAR plans collectively reported 714 member complaints, 1,539 member appeals, and 446 provider complaints in 2019 SFY Q3. STAR plans collectively reported 670 member complaints, 1,797 member appeals, and 509 provider complaints in SFY19 Q4.

The total number of STAR+PLUS complaints and appeals received by plans increased from 3,363 in 2019 SFYQ3 to 3,399 in SFY19 Q4. STAR+PLUS plans collectively reported 1,350 member complaints, 1,716 member appeals, and 297 provider complaints in SFY19 Q3. STAR+PLUS plans collectively reported 1,242 member complaints, 1,863 member appeals, and 294 provider complaints for SFY19 Q4.

The total number of STAR Kids complaints and appeals received by plans decreased from 1,771 in SFY19 Q3 to 1,723 in 2019 SFY Q4. STAR Kids plans collectively reported 166 member complaints, 1,521 member appeals, and 84 provider complaints in SFY19 Q3. STAR Kids plans collectively reported 149 member complaints, 1,494 member appeals, and 80 provider complaints in SFY19 Q4.

The total number of DMO complaints and appeals received by plans decreased from 799 in SFY19 Q3 to 593 in SFY19 Q4. DMO plans collectively reported 414 member complaints, 364 member appeals, and 21 provider complaints in SFY19 Q3. DMO plans collectively reported 270 member complaints, 309 member appeals, and 14 provider complaints in SFY19 Q4.

STAR

Member Appeals

- FirstCare did not meet the performance standards for timely resolution of member appeals in Q4.
    - FirstCare, in MRSA West, was out of compliance for standard 30-day appeals reporting at 97%. Per the MCO, the Appeals and Grievances team sent the inquiry to the Pharmacy team timely. The MCO experienced a delay in the internal workflow from Pharmacy team to a Medical Director (MD) for review thus causing the delayed decision. To improve oversight of the internal workflow process, the Appeals and Grievances team started sending bi-weekly reports to the MD's on cases to provide visibility on case load and the Appeals and Grievances staff will follow-up with MD's as necessary prior to the due date as well as escalate to Management for cases approaching the due date.

Member Complaints

- Amerigroup, Driscoll Children's, and Superior did not meet the performance standards for timely resolution of member complaints in Q4.
    - Amerigroup, in Harris, was out of compliance for standard 30-day timely resolution of member complaints reporting at 92%. Amerigroup reviewed the complaint and found the complaint was resolved in 25 days with a resolution letter sent on day 25. Production of the Q4 report resolution of over 30 days was caused by a glitch in the system when an auditor opened the file after the 30 days and caused the date change of the complaint closure, which should not have changed the complaint resolution date. Amerigroup is making system updates, so this new issue does not continue to happen.
    - Amerigroup, in MRSA Northeast, was out of compliance for standard 30-day timely resolution of member complaints reporting at 80%. Amerigroup reviewed the complaint and found the complaint was resolved in 25 days with a resolution letter sent on day 25. Production of the Q4 report resolution of over 30 days was caused by a glitch in the system when an auditor opened the file after the 30 days and caused the date change of the complaint closure, which should not have changed the complaint resolution date. Amerigroup is making system updates, so this new issue does not continue to happen. Amerigroup is submitting a new Q4 report and detail for the N1 MRSA Northeast Star

report at 100%. This noncompliance will appear on the Q1 SFY2020 remedy log for late/inaccurate reporting.

- Driscoll Children's, in Hidalgo, was out of compliance for standard 30-day timely resolution of member complaints reporting at 90%. Per the MCO, the reason for delay in resolution is directly related to staffing and the volume of complaints. This was the third occurrence for non-compliance and Driscoll was placed on a CAP. Driscoll will continue to strive for 100% of complaints to be processed within 30 days and encourage responses in order to meet the deadline.
- Driscoll Children's, in Nueces, was out of compliance for standard 30-day timely resolution of member complaints reporting at 89%. Per the MCO, the reason for delay in resolution is directly related to staffing and the volume of complaints. Driscoll will continue to strive for 100% of complaints to be processed within 30 days and encourage responses in order to meet the deadline.
- Superior, in Bexar, was out of compliance for standard 30-day timely resolution of member complaints reporting at 97%. Per the MCO, the due date for this complaint was entered incorrectly at intake on 1 case, therefore the case was closed late. Superior's intake supervisor is monitoring the dates entered at intake to ensure accuracy of all dates.

Provider Complaints

- Driscoll Children's and Molina did not meet the performance standards for timely resolution of provider complaints in Q4.
  - Driscoll Children's, in Hidalgo, was out of compliance for standard 30-day timely resolution of provider complaints reporting at 79%. Per the MCO, the reason for delay in resolution is directly related to staffing and the volume of complaints. Four quality of care complaints missed the metric. Various steps were made including an action plan for PCP staff and enforcing office policy regarding turning away patients as well as patient satisfaction surveying, a letter being sent to the provider requesting the member be refunded the money paid for Medicaid covered services, informing the Legally Authorized Representative (LAR) that she could choose another PCP that can accommodate hers and her son's needs, and providing education to PCP staff.
  - Driscoll Children's, in Nueces, was out of compliance for standard 30-day timely resolution of provider complaints reporting at 66%. Per the MCO, the reason for delay in resolution is directly related to staffing and the volume of complaints. There were two quality of care complaints, one accessibility/availability of services, one miscellaneous, and one related to pharmacy benefit manager. Steps were taken to resolve the complaints including assisting with requesting another DME company, a change in PCP provider following a member request, assisting a member who recently moved from Nueces to El Paso SDA to find a new PCP in El Paso, sending a letter to the provider reminding them of the federal/state guidelines surrounding balance billing, and insuring a member received medication needed.
  - Molina, in Dallas, was out of compliance for standard 30-day timely resolution of provider complaints reporting at 86%. Molina's Response for both SDAs – Q4 performance reflects that Molina did not meet the contractual performance levels and benchmarks. Molina did not attain a resolution rate of 98% for all STAR Provider

Complaints during this review quarter. There were two complaints that were not correctly categorized in the Appeals and Grievance system that delayed the timeframe for completion.

- Molina, in Hidalgo, was out of compliance for standard 30-day timely resolution of provider complaints reporting at 97%. Molina's Response for both SDAs – Q4 performance reflects that Molina did not meet the contractual performance levels and benchmarks. Molina did not attain a resolution rate of 98% for all STAR Provider Complaints during this review quarter. There were two complaints that were not correctly categorized in the Appeals and Grievance system that delay the timeframe for completion.

STAR+PLUS

Member Appeals

- Amerigroup did not meet the performance standards for timely resolution of member appeals in Q4.
  - Amerigroup, in El Paso, was out of compliance for standard 30-day appeals reporting at 91%. Per the MCO, this issue was caused by a glitch in their migration to Genesys telephony system. This is the only deliverable that has not been resubmitted at this time.

Member Complaints

- Amerigroup and Superior did not meet the performance standards for timely resolution of member complaints for Q4.
  - Amerigroup, in Bexar, was out of compliance for standard 30-day timely resolution of member complaints reporting at 96%. Amerigroup reviewed the complaint and found the complaint was resolved in 25 days with a resolution letter sent on day 25. Production of the Q4 report resolution of over 30 days was caused by a glitch in the system when an auditor opened the file after the 30 days and caused the date change of the complaint closure, which should not have changed the complaint resolution date. Amerigroup is making system updates, so this new issue does not continue to happen. Amerigroup has resubmitted this deliverable on 12/6/19, this area is no longer non-compliant, the resubmitted deliverables shows as 100%.
  - Amerigroup, in El Paso, was out of compliance for standard 30-day timely resolution of member complaints reporting at 94%. Amerigroup reviewed the complaint and found the complaint was resolved in 25 days with a resolution letter sent on day 25. Production of the Q4 report resolution of over 30 days was caused by a glitch in the system when an auditor opened the file after the 30 days and caused the date change of the complaint closure, which should not have changed the complaint resolution date. Amerigroup is making system updates, so this new issue does not continue to happen. Amerigroup resubmitted this deliverables on 12/6/19. With resubmission, Amerigroup is no longer out of compliance as the resubmitted deliverable shows as 100%.
  - Superior, in Bexar, was out of compliance for standard 30-day timely resolution of member complaints reporting at 97%. Bexar at 97.33% due to Dental at 33.33%, 1 of 3 completed within 30 days. Both cases were resolved on day 31 as Superior had had issues in obtaining the information that they needed from the provider timely.

- Superior, in MRSA Central, was out of compliance for standard 30-day timely resolution of member complaints reporting at 94%. MRSA Central at 94.44% due to Dental at 80%, 4 of 5 completed within 30 days and case was originally assigned to a specialist that is no longer with DentaQuest. The open role & reassignment caused the case to be resolved outside of the required timeframe. All open roles have been filled as of 10/7/19.

- Superior, in MRSA West, was out of compliance for standard 30-day timely resolution of member complaints reporting at 97%. MRSA Central at 94.44% due to Dental at 80%, 4 of 5 completed within 30 days and case was originally assigned to a specialist that is no longer with DentaQuest. The open role & reassignment caused the case to be resolved outside of the required timeframe. All open roles have been filled as of 10/7/19.

Provider Complaints

- Cigna-HealthSpring did not meet the performance standards for timely resolution of provider complaints.

    - Cigna-HealthSpring, in Tarrant, was out of compliance for standard 30-day timely resolution of provider complaints reporting at 91%. The root cause related to an investigator neglecting to send the complaint to claims timely. The investigator received coaching along with additional training to ensure timeliness of complaints.

STAR Kids

Member Appeals

- Driscoll Children's did not meet the performance standards for timely resolution of member appeals in Q4.

    - Driscoll Children's, in Nueces, is out of compliance for standard 30-day appeals reporting at 80%. Per Driscoll, one appeal was not resolved within 30 days. The appeal that was not resolved within the timeframe was due to the Driscoll Health Plan Medical Director not completing the review within the required timeframe. All physician reviewers are monitored for their appeal status timeline weekly. Clinical Appeal Coordinators send messages to the MD reviewers to inform them of their timeline to date of the appeal and ask physicians if an extension needs to be requested to stay in compliance with the 30 day timeline.

Member Complaints

- Amerigroup, Children's Medical Center, and Driscoll Children's did not meet the performance standards for timely resolution of member complaints for Q4.

    - Amerigroup, in Harris, was out of compliance for standard 30-day timely resolution of member complaints reporting at 80%. Root cause of the complaints stemmed from the provider balance billing, suspected fraud waste or abuse and dissatisfaction with providers. In each instance Member Advocates worked with members to rectify the issue and ensure optimal customer satisfaction which included member and provider education, billing issue resolution, adequate claims processing, assisting members rectify grievances with providers or assisting them in locating a new provider and providing resolution regarding claims and walking member through the proper process for their attendant to

receive his/her paychecks timely. This noncompliance will appear on the Q1 SFY2020 remedy log for late/inaccurate reporting.

- Children's Medical Center, in Dallas, was out of compliance for standard 30-day timely resolution of member complaints reporting at 93%. One complaint was not tracked appropriately during a Compliance Department staff member's transition to a new role within the health plan. All Compliance Department staff have been cross trained in Complaint Processing. Alerts have been added to internal tracking systems.
- Driscoll Children's, in Hidalgo, was out of compliance for standard 30-day timely resolution of member complaints reporting at 75%. The reason for delay in resolution is directly related to staffing and the volume of complaints. One quality of care complaint that missed metrics was regarding the LAR expressing dissatisfaction with the decrease in PCPs services from 12.25 hours to 6.50 hours. LAR stated she was going to change health plans because she was not happy with Driscoll Health Plan. LAR switched health plans. One quality of care complaint that missed metrics was regarding the LAR being upset due to provider's office staff being rude when visiting the office for members physical needed for school. There was some miscommunication between the LAR and provider staff. Staff informed LAR member required an exam for THSteps and LAR just wanted the physical form signed without an exam. Appointment was made by staff but was rescheduled. One miscellaneous complaint that missed metrics was regarding the member being balance billed for services provided. Driscoll Health Plan research did not find any outstanding balances in account numbers provided.
- Driscoll Children's, in Nueces, was out of compliance for standard 30-day timely resolution of member complaints reporting at 86%. The reason for delay in resolution is directly related to staffing and the volume of complaints. One accessibility/availability complaint that missed the metric was regarding the member moving from Nueces to Tarrant County and not being able to find a PCP for her son or an OB-GYN for herself. Member was able to be seen by a provider in the area she moved to and that she is in the process of changing health plans.

Provider Complaints

- Driscoll Children's did not meet the performance standards for timely resolution of provider complaints for Q4. Per Driscoll, the reason for delay in resolution is directly related to staffing and the volume of complaints.
  - Driscoll Children's, in Hidalgo, was out of compliance for standard 30-day timely resolution of provider complaints reporting at 88%. Reason for delay in resolution is directly related to staffing and the volume of complaints. One claims processing complaint that missed metrics was regarding the provider stating the claim was paid incorrectly. Claims department directed third party administrator to reprocess and pay additional funds to the provider. Another claims processing complaint that missed metrics was regarding the provider stating claims are not paid at their contract rate. Driscoll did not receive a response from the provider after contacting them and speaking to them.

Dental

Member Appeals

- DentaQuest did not meet the performance standards for timely resolution of member appeals on Q4.
    - DentaQuest was out of compliance for standard 30-day appeals reporting at 83%. Per the DMO, non-compliance was due to staffing deficiencies and the learning curve of new employees. All open positions have been filled as of 10/7/19.

Member Complaints

- DentaQuest did not meet the performance standards for timely resolution of member complaints for Q4.
    - DentaQuest was out of compliance for standard 30-day timely resolution of member complaints reporting at 66%. Per the DMO, non-compliance was due to staffing deficiencies and the learning curve of new employees. All open positions have been filled as of 10/7/19.

Complaints Received by the State

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

Overall OMCAT and MCCO complaints in SFY19 Q3 were 1,594 and in SFY19 Q4 1,371. ***Attachment O*** provides complaints performance summary.

OMCAT received a total of 652 complaints through its helpline in SFY19 Q4 showing a 10% decrease in complaints as compared to SFY Q3 at 721 total complaints. The percentage of change, by each program, between SFY Q3 and SFY Q4 is as follows: STAR (7% decrease), STAR+PLUS (10% decrease), STAR Kids (16% decrease), and the Dental program had no change. The top three reasons for OMCAT complaints in the fourth quarter are access to long-term services and supports, prescription services - other insurance, and access to durable medical equipment (DME).

MCCO received a total of 17 legislative complaints in SFYQ4 showing a 59% decrease as compared to the SFY Q3 at 41 total complaints. The percentage of change, by each program, between SFY Q3 and SFY Q4 is as follows: STAR (14% decrease), STAR+PLUS (55% decrease), and STAR Kids (91% decrease). The dental program received one complaint in Q3 and received zero complaints in Q4 (100% decrease). The top three reasons for legislative complaints in SFY Q4 are payment dispute, denial of a claim, and MCO/provider contract issues.

MCCO received a total of 121 member complaints in SFY Q4 with a 2% increase as compared to SFY Q3 at 119 total complaints. The percentage of change, by each program, between SFY Q3 and SFY Q4 is as follows: STAR (37% decrease), STAR+PLUS (21% increase), and STAR Kids (17% increase). The dental program received 8 complaints in SFY Q3 and 3 complaints in SFY Q4 (63% decrease). The top three reasons for member complaints in SFY Q4 are access to care, DME, and ANE Abuse, Neglect, and Exploitation.

MCCO received a total of 581 provider complaints in SFY Q4 with a 19% decrease as compared to SFY19 Q3 at 713 total complaints. The percentage of change, by program, between SFY Q3 and SFY Q4 is as follows: STAR (1% decrease), and STAR+PLUS (23% decrease), STAR Kids (57% decrease) and

the Dental program (5% increase). The dental program received 21 complaints in SFY Q3 and 22 complaints in SFY Q4. The top three reasons for provider complaints in SFY Q4 are denial of claim, payment disputes, and credentialing.

Provider Fraud and Abuse

MCOs and DMOs are required to send referrals regarding Medicaid waste, abuse, or fraud to the HHSC Office of Inspector General (OIG). Please see ***Attachments R1 and R2*** for MCO and DMO referral details. The OIG received a total of 65 fraud and abuse referrals from MCOs in SFY19 Q3 and 64 in Q4. These cases can have multiple dispositions; therefore, disposition total will not add up to the total number of referrals received. In Q4, OIG launched an MPI full scale investigation of 12 cases, information was transferred to existing full scale case for 2 cases, referred 3 cases to the federal OIG, referred 7 cases to the Texas State Board of Pharmacy, referred 18 cases to Medicaid Fraud Control Unit (MFCU), transferred 13 cases to OIG Medical Services, referred 1 to Board of Nurse Examiners, referred 1 to MCO/SIU (Special Investigative Unit), 1 referred to HHSC, and closed 53 cases.

The OIG's office received a total of 33 fraud and abuse referrals from DMOs in SFY19 Q3 and 16 in Q4. In Q4, OIG launched an MPI full-scale investigation for 2 cases, transferred 2 case's information into existing full-scale cases, transferred 3 cases to OIG Medical Services, referred 2 cases to the MFCU, and closed 13 cases.

Hotline Performance

- The MCOs and DMOs must have a toll-free hotline that members can call 24 hours a day, 7 days a week. The MCOs are required to meet the following hotline performance standards:
- 99% of calls must be answered by the fourth ring;
- ≤1% busy signal rate for all calls (for behavioral health (BH), no incoming calls receive a busy signal;
- 80% of all calls must be answered by a live person within 30 seconds (not applicable for provider hotlines);
- ≤ 7% call abandonment rate; and
- ≤ 2 minutes average hold time.

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

Member Hotline **(STAR/STAR+PLUS/CHIP - SFY19 Q4)**

- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs, except Amerigroup (75%), Dell Children's (73%), and Texas Children's (63%) met the 80% standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

Member Hotline **(STAR Kids - SFY19 Q4)**

- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs met the 80% standard for answered by a live person within 30 seconds except for Texas Children's (63%). Per the MCO, the call hold rate for month 1 was 60.76%, month 2 is 59.89%, and month 3 is 67.35%. Call volumes fluctuated, month 1 had higher call volumes, and

months 2 and 3 had lower volumes. The MCOs resolution was to male internal changes to our technology and will continue to assess the team.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

Behavioral Health Hotline **(STAR/STAR+PLUS/CHIP- SFY19 Q4)**
- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs met the 80% standard for answered by a live person within 30 seconds.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOs average hold times were under two minutes.

Behavioral Health Hotline **(STAR Kids - SFY 19 Q4)**
- All MCOs met the requirement to answer calls by the fourth ring.
- 80% standard for answered by a live person within 30 seconds
- All MCOs, except Community First (10%) and Texas Children's (10%) met the ≤ 7% abandoned calls standard. Community First has begun coaching staff on answering the call immediately when it rings. The MCO reported examples of members getting to the agent but hanging up prior to being answered. Focusing on this behavior has already helped with September and October's abandonment rate. For Texas Children's, the variance is due to fluctuations in call volumes. The abandonment rate month 2 was 10%, and month 3 was 8.7%. For call variance, month 1 had higher call volume, months 2 and 3 had lower call volumes. Month 3 call hold rate was 76.19%. The MCO's resolution is to work with the vendor to add additional staffing for these lines of businesses where standards were not met.
- All MCOS average hold times were under two minutes.

Provider Hotline **(STAR/STAR+PLUS/CHIP - SFY19 Q4)**
- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

Provider Hotline **(STAR Kids - SFY19 Q4)**
- All MCOs met the requirement to answer calls by the fourth ring.
- All MCOs had ≤1% busy signal rate.
- All MCOs met the ≤ 7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

DMO member and provider hotline performance for DentaQuest and MCNA met all standards throughout SFY19.

5.1 Appeals Issues: New and Continued

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

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

this section to provide updates on appeals-related issues identified in previous reports. When applicable, the state should also note when issues are resolved.
If the state is not aware of appeals issues, this section should be blank.
**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

5.2 Anticipated Changes to Appeals

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

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

☐ HHSC plans to add an External Review Organization to the existing appeal process and is in the beginning stages of planning for this initiative. The State will provide an update in the next annual report.

6. Quality

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

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

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

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

☐ (Required) The state has attached the quality measures in Appendix X.

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

6.1 Quality Issues: New and Continued

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

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

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

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

6.2 Anticipated Changes to Quality

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

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

7. Other Demo Specific Metrics

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

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

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

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

☐ (If applicable) The state has attached completed the other metrics in Appendix X.

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

7.1 Other Metric Issues: New and Continued

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

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

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

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

7.2 Anticipated Changes to Other Metrics

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

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

8. Financial/Budget Neutrality

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

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

8.1 Financial/Budget Neutrality Issues: New and Continued

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

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

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

DY8 Q3 April – June 2019
Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 7 (Apr 2019)**	**Month 8 (May 2019)**	**Month 9 (Jun 2019)**	**Total for Quarter Ending 6/2019**
Adults	269,211	268,917	269,839	807,967
Children	2,541,719	2,523,345	2,520,569	7,585,633
AMR	354,002	353,291	353,563	1,060,856
Disabled	408,513	406,768	407,341	1,222,622

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 7 (Apr 2019)**	**Month 8 (May 2019)**	**Month 9 (Jun 2019)**	**Total for Quarter Ending 6/2019**
Adults in MRSA	-	-	-	-
Foster Care	35,115	35,076	35,034	105,225
Medically Needy	197	200	174	571
CHIP-Funded	251,013	251,678	254,293	756,984
Adoption Subsidy	-	-	-	-
STAR+PLUS 217-Like HCBS	18,322	18,375	18,380	55,078

DY8 Q4 July – September 2019

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	**Month 10 (Jul 2019)**	**Month 11 (Aug 2019)**	**Month 12 (Sep 2019)**	**Total for Quarter Ending 10/2019**
Adults	274,648	272,579	273,860	821,087
Children	2,533,644	2,527,087	2,526,972	7,587,703
AMR	353,898	353,564	353,444	1,060,906
Disabled	406,539	404,787	405,260	1,216,586

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	**Month 10 (Jul 2019)**	**Month 11 (Aug 2019)**	**Month 12 (Sep 2019)**	**Total for Quarter Ending 9/2019**
Adults in MRSA	-	-	-	-
Foster Care	35,002	34,926	34,835	104,763

Medically Needy	190	185	185	559
CHIP-Funded	255,238	257,969	260,247	773,454
Adoption Subsidy	-	-	-	-
STAR+PLUS 217-Like HCBS	18,450	18,494	18,343	55,287

8.1 Anticipated Changes to Financial/Budget Neutrality

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

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

9. Demonstration Operations and Policy

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

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

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

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

Claims Summary

The MCOs and DMOs submit monthly claims summary reports (CSR) to HHSC for the following services: acute care, behavioral health (BH), vision services, pharmacy claims, and long-term services and supports (LTSS). The standards for the clean claims and appealed claims follow:

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

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

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

STAR (SFY 19 Q4 Month 3)
Acute Care Claims

- Molina

Behavioral Health Services Claims

- Molina

Vison Services Claims

- Molina

STAR+PLUS (SFY 19 Q4 Month 3)
Acute Care Claims

- Molina
- Superior

Behavioral Health Services Claims

- Amerigroup
- Molina
- Superior

Vison Services Claims

- Molina

Long Term Care Claims

- Molina

STAR Kids (SFY 19 Q4 Month 3)
Acute Care Claims

- Community First

Long Term Care Claims

- Aetna

Litigation Summary

Consideration 1:

Type of Consideration	*Ongoing litigation*
Summary of Consideration	*Frew, et al. v. Phillips, et al.* (commonly referred to as *Frew*), was filed in 1993, and was brought on behalf of children under age 21 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the Federal Medicaid Act. The lawsuit was settled by a consent decree in 1996. The decree requires numerous state obligations and is monitored by the Court. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to eleven corrective action orders to bring the state into compliance with the consent decree and to increase access to EPSDT benefits. Currently, four of the eleven corrective action orders and their related consent decree paragraphs are fully dismissed: (1) Check-Up Reports and Plans for Lagging Counties, (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, (3) Transportation Program, and (4) Health Care Provider Training. In 2014, the parties jointly agreed to vacate most of the Toll-Free Numbers corrective action order, and the related consent decree paragraphs. One toll-free number remains under the corrective action order and court monitoring. On January 20, 2015, the district court vacated the Adequate Supply of Health Care Providers

	corrective action order and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. Plaintiffs appealed. On March 28, 2016, the Fifth Circuit affirmed most of the district court's opinion, but vacated and remanded to the district court for further proceedings portions of the district court's order regarding provider "shortages."
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 May 2019) at 2,996,251.
If Issue, Remediation Plan and Timeline for Resolution / Updates in Status if Previously Reported	HHSC and DSHS will continue to follow the obligations in the remaining portions of the consent decree and corrective action orders until they are dismissed by the court.

10. Implementation Update

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

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

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

Health IT Strategic Plan Update

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

At the end of August, HHSC requested guidance from CMS about eliciting public feedback on the plan. CMS recommended that HHSC provide the public an opportunity to provide feedback. HHSC received guidance from CMS that delaying the October 1, 2019 deliverable to allow for public review and comments was appropriate and approved. HHSC will post the document for stakeholder feedback and intends to finalize the report by the end of November. After finalizing the document, HHSC will route the document internally for approval to submit to CMS. CMS granted HHSC an extension until March 31, 2020.

11. Demonstration Evaluation Update

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

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

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

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

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

HHSC completed the following 1115 Waiver evaluation activities for SFY19 Q3 and Q4:

- HHSC entered contract negotiations with the external evaluator, Texas A&M University (TAMU)
- HHSC created an 1115 Data Dissemination workgroup to manage all 1115-related data transfers. HHSC also finalized the data dissemination schedule, including a timeline for delivering information to TAMU and HHSC contacts responsible for providing specific data elements.

- HHSC analysts finalized the parameters and data sources necessary for Medicaid data pulls, and analysts began assembling data
- HHSC scheduled an initial check-in with the Principal Investigator from TAMU towards the end of Q4 and met in early SFY20 Q1

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

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Procurement of Independent External Evaluator	9/1/2019	*HHSC received internal approvals to begin contracting with TAMU. HHSC delivered contract to TAMU prior to 9/1/19. TAMU requested changes at the end of SFY19 and HHSC is reviewing.*	*No issues anticipated at this time*
Interim Evaluation Report	9/30/2021 *(or upon application for renewal)*		*No issues anticipated at this time*
Summative Evaluation Report	3/30/2024		*No issues anticipated at this time*

12. Other Demonstration Reporting

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

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

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

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list any other deliverables related to this demonstration and their due dates. Note that deliverables associated with the evaluation should be listed separately in the Demonstration Evaluation Update section.

STAR+PLUS –

• Awards made December 10, 2019 with an anticipated start date of of September 1, 2020. The awards are as follows:

- Harris service area: Aetna, Amerigroup, United Health Care
- Hidalgo service area: Aetna, Molina Inc., Superior
- Dallas service area: Aetna, Amerigroup, Superior
- Bexar service area: Aetna, Amerigroup, Superior
- North East service area: Molina Co., United Health Care
- Tarrant service area: Amerigroup, United Health Care
- West service area: Superior, United Health Care

- Central service area: Superior, United Health Care
- Travis service area: Superior, United Health Care
- El Paso service area: El Paso Health, Superior
- Nueces service area: Superior, United Health Care
- Jefferson service area: Amerigroup, United Health Care
- Lubbock service area: Superior, United Health Care

Dental –

- Contracts were awarded October 31, 2019 to 3 vendors DentaQuest USA Insurance Company, Inc., MCNA Insurance Company, and United Healthcare Insurance Company. Readiness activities are underway and the anticipated start date is September 1, 2020.

Delivery System Reform Incentive Payment Program

Delivery System Reform Incentive Payment Program (DSRIP) evolved from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system. DSRIP providers report on required categories at the provider system level, rather than the project level. In Q3 of DY8, HHSC submitted the changes to the Program Funding and Mechanics Protocol for DY9-10 to CMS. Providers had their first opportunity to report performance achievement of DY7 Category C measures.

In DY8, 2,398 Category C measures were eligible to report Performance Year 1 (PY1, which is 01/01/18 – 12/31/18) to potentially earn payment for the DY7 achievement milestone. Measure Bundle and measure selections were approved as part of the DY7-8 RHP Plan Update in June 2018, and the data reported for PY1 reflects six months of improvement effort following selection approval. Overall, 72% of measures eligible to report achievement were reported as fully achieving the DY7 goal in PY1, and an additional 7% of measures reported partially achieving the DY7 goal in PY1. The table below provides a summary of reported achievement by measure type, and Attachment Z includes all Category C reporting and summaries by measure, Measure Bundle, provider type, measure type, and region.

Measure Type	**P4P Measures Eligible to Report**	**P4P Measures Reported in DY8**	**P4P 100% of AM-7.x Goal Achieved in PY1**	**P4P Partial Achievement of AM-7.x Goal in PY1**	**P4P 0% of AM-7.x Goal Achieved in PY1**
Cancer Screening	103	100%	72%	8%	20%
Clinical Outcome	480	99%	72%	5%	23%
Hospital Safety	231	100%	61%	4%	35%
Immunization	240	97%	75%	6%	19%
Population Based Clinical Outcomes	110	100%	62%	5%	34%
Process	1212	99%	75%	8%	17%
Quality of Life	7	100%	100%	0%	0%
All Measures	**2398**	**99%**	**72%**	**7%**	**21%**

Data includes only measures with a baseline that ends 12/31/2017 and does not include measures with a delayed baseline.

In total for April DY8 reporting, based on available Intergovernmental Transfer (IGT), $1,264,710,775 was paid for DSRIP in July 2019, for a total of $16 billion in DY1-8 DSRIP payments to date. DSRIP continues to provide technical assistance to correct reported baselines and performance. **Attachment X** includes DSRIP providers overall status for April DY8 reporting. **Attachment Y** provides estimated remaining payments for DY7-8. Q4 updates are not available until after the reporting period and will be reported in the semiannual report.

HHSC is in discussions with CMS regarding the Transition Plan for when DSRIP funding ends, as required by the 1115 Waiver approval. Throughout the development of the Transition Plan, HHSC has engaged stakeholders, including through a series of stakeholder meetings in the fall of 2018 to solicit ideas on future programs and in the fall of 2019 for feedback on the Transition Plan. HHSC is actively engaged in work to meet drafted milestones included in the Transition Plan, including ensuring a continued robust stakeholder engagement process. HHSC developed a partner engagement plan, which can be found on the DSRIP website at https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/dsrip-transition-partner-engagement-plan.pdf. Formal stakeholder engagement includes monthly email updates to stakeholders, quarterly stakeholder webinar or in-person meetings to discuss the Transition Plan progress, monthly legislative staff briefings, and Executive Waiver Committee meetings. In addition, the DSRIP team responds to all inquiries submitted through the DSRIP waiver team email mailbox and has made presentations on the transition plan and activities at a number of conferences and learning collaboratives at stakeholder request.

12.1 Post Award Public Forum

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

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

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

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

☐ The state has provided the summary of the post-award forum (due for the period during reporting during which the forum was held and in the annual report).

☒ There was not a post-award public forum held during this reporting period and this is not an annual report.

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

13. Notable State Achievements and/or Innovations

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

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

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

14. Report Attachments

Attachment A - Managed Care Organizations by Service Delivery Area. The attachment includes a table of the health and dental plans by Service Delivery Area.
Attachment B1 - Enrollment Summary (SFY19). The attachment includes annual and quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.
Attachment B2 -- Disenrollment Summary (SFY19). The attachment includes annual and quarterly Dental, STAR and STAR+PLUS disenrollment summaries.
Attachments C1, C2, C3 - Provider Network and Methodology. The attachments summarize STAR, STAR Kids, and STAR+PLUS network enrollment by MCOs, SDAs, and provider types. It also includes a description of the methodology used for provider counts and terminations.
Attachments D - Out-of-Network Utilization. The attachments summarize Dental, STAR, STAR Kids, and STAR+PLUS out-of-network utilization.
Attachment E - Distance Standards. The attachment shows the State's distance standards by provider type and county designation.
Attachment H1-H4 - Network Access Analysis. The attachments include the results of the State's analysis for PCPs, main dentists, and specialists.
Attachment L - Enrollment Broker Summary Report. The attachment provides a summary of outreach and other initiatives to ensure access to care.
Attachments M1-M4 - Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.
Attachments N1-N3 - MCO Complaints. The attachment includes 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.
Attachment Q - Members with Special Healthcare Needs Report. The attachment represents total MSHCN enrollment in STAR, STAR Kids, and STAR+PLUS during the prior fiscal year.
Attachment R1-R2 - Provider Fraud and Abuse. The attachments represent a summary of the referrals that STAR, STAR Kids, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period.
Attachment S - Service Utilization. This attachment displays Enrollment and Expenditure Graphs for the previous fiscal year (SFY18).

Attachments V1-V4 - Claims Summary (SFY 2018). The attachments are summaries of the MCOs' claims adjudication results.

Attachment X - DSRIP Provider Summary.

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

Attachment Z - DSRIP Category C Summary Workbook