

Medicaid Section 1115 Monitoring Report
 Texas Healthcare Transformation and Quality Improvement Program
 Demonstration Year DY8: October 1, 2019 – September 30, 2020
 State Fiscal Year FY20: September 1, 2019 – August 31, 2020
 Submitted on March 1, 2021

**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: January 15, 2021 Expiration date: September 30, 2030
Demonstration Goals and Objectives	<p>The Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver enables the State to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:</p> <ul style="list-style-type: none"> • Expand risk-based managed care statewide; • Support the development and maintenance of a coordinated care delivery system; • Improve outcomes while containing cost growth; and • Transition to quality-based payment systems across managed care and providers.

2. Executive Summary

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) 9 and State Fiscal Year 2020 (SFY20), from September 1, 2019, through August 31, 2020. This report provides the annual 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 SFY20, COVID-19 created a public health emergency (PHE) impacting the 1115 Transformation Waiver.

During SFY20, 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*). Effective September 1, 2020, Children's Medical Center no longer is contracted for STAR Kids in the Dallas SA.

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

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

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

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. Enrollment growth during the public health emergency has been significant.

In SFY20, from SFY Q3 to SFY Q4 total enrollment increased in STAR (9.06%), increased in STAR Kids (2.67%), and increased in STAR+PLUS (0.94%). The Dental Program increased (5.62%) 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 3% or less throughout SFY20. During Q4 the market share for STAR was at 44%, for STAR Kids 2%, and STAR+PLUS 7%. Market share distribution in the Dental Program remained steady as DentaQuest finished Q4 with 58% and MCNA with 42%.

The State's enrollment broker, MAXIMUS, submits monthly and quarterly reports summarizing unduplicated enrollments (See **Attachment L, August 2020, pg. 4**). 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 required by CMS for this demonstration.

The State's enrollment broker, MAXIMUS, reported unduplicated enrollments for SFY20 Q3, encompassing March 2020, April 2020, May 2020, with effective dates of April 1st, May 1st, June 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,664,697. The Dental Program reported total enrollments for the same time period with an average of 2,896,370.

Unduplicated enrollments for SFY20 Q4, encompassing June 2020, July 2020, August 2020, with effective dates of July 1st, August 1st, and September 1st for STAR, STAR+PLUS, and STAR Kids with an average of 3,999,180. The Dental Program reported total enrollments for the same time period with an average of 3,159,270.

For SFY20, the four-quarter average for STAR, STAR+PLUS, and STAR Kids is 3,664,323 and the average among all four quarters for The Dental Program is 2,875,282.

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 (DY9 Q1 October – December 2019)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	307,804
Children	2,707,065
Aged and Medicare Related (AMR) (non-MRSA - pre Sep14)	382,799
Disabled	417,772

Enrollment Counts (DY9 Q2 January – March 2020)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	307,798
Children	2,705,709
AMR (non-MRSA - pre Sep14)	382,105
Disabled	415,785

Enrollment of Members with Special Health Care Needs

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

All STAR Kids and STAR+PLUS members are deemed to be MSHCN, and as such, all STAR Kids and STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR Kids and STAR+PLUS MCOs are required to provide service coordination to all members. STAR MCOs must identify MSHCN based on criteria outlined in the managed care contract. STAR MCOs are required to provide service management to MSHCN, unless the member declines service management or is unable to be reached.

Attachment Q outlines details by SDA and MCO. In SFY20 Q4, STAR MCOs reported a total of 85,992 children and adults identified as MSHCN. STAR MCOs reported 20.91% of MSHCN had a service plan and 79.09% did not have a service plan (See **Attachment Q**). The overall percentage of STAR MSHCN with service plans has increased slightly since the last reporting period (SFY20 Q3 17.91%). Four MCOs reported more than 60% of MSHCN had a service plan (Aetna, Driscoll, Parkland, and United). Five MCOs reported less than 10% had a service plan (Amerigroup, Dell Children’s, FirstCare, Molina Healthcare, and Texas Children’s Health Plan). Harris SDA holds the most MSHCN with 16.61% (23,376) of all reported STAR MSHCN. Dallas SDA holds the second-most reported MSHCN with 16.54% (13,628). HHSC regularly communicates with STAR MCOs on the reported data.

Disenrollment

The State received no disenrollment requests during SFY20 Q3 or Q4.

Provider Network

This subsection includes quarterly healthcare provider counts for STAR, STAR+PLUS, STAR Kids, and dental provider counts for the Dental Program (See **Attachment C2**). Provider Network Count Methodology may be found in **Attachment C1**.

Across the STAR program statewide, the MCOs reported an increase (0.7%) in unique PCP providers, between SFY20 Q3 and SFY20 Q4. The MCOs reported an increase (3.4%) for the STAR+PLUS program in unique PCP providers, between SFY20 Q3 and SFY20 Q4. The MCOs reported an increase (2.0%) for the STAR Kids program in unique PCP providers, between SFY20 Q3 and SFY20 Q4.

Across the STAR program statewide, the MCOs reported an increase (4.6%) in unique specialists, between SFY20 Q3 and SFY20 Q4. The MCOs reported an increase (4.1%) for the STAR+PLUS program in unique specialists, between SFY20 Q3 and SFY20 Q4. The MCOs reported an increase (1.2%) for the STAR Kids program in unique specialists, between SFY20 Q3 and SFY20 Q4. There was no change in the dental program in unique specialists.

Across the STAR population statewide, the MCOs reported an increase (1.9%) in unique dental providers, between SFY20 Q3 and SFY20 Q4. The MCOs reported a increase (0.6%) for the STAR+PLUS population in unique dental providers, between SFY20 Q3 and SFY20 Q4. The MCOs reported no change for the STAR Kids program in unique dental providers, between SFY20 Q3 and SFY20 Q4. Across the dental program statewide, the DMOs reported an increase (2.2%) in unique primary dental providers between SFY20 Q3 and SFY20 Q4.

Across the STAR program statewide, the MCOs reported an increase (1.7%) in unique pharmacists, between SFY20 Q3 and SFY20 Q4. The MCOs reported no change for the STAR+PLUS program in unique pharmacists, between SFY20 Q3 and SFY20 Q4. The MCOs reported an increase (1.8%) for the STAR Kids program in unique pharmacists, between SFY20 Q3 and SFY20 Q4.

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in SFY20. The MCOs reported a variety of reasons for provider termination for PCPs and specialists. The top three reasons for PCP terminations included provider left group practice, provider moved, and termination requested by provider. The top three reasons for specialist terminations included provider left group practice, termination requested by provider, and program integrity issues.

Accessibility and Language Compliance

HHSC requires MCOs to ensure PCPs are accessible 24 hours per day, seven days a week. Managed care contracts outline specific criteria for what constitutes full accessibility compliance. For example, providers must offer after-hours telephone availability through an answering service, recorded messages with contact information for the on-call PCP, or call forwarding that routes the caller to the on-call PCP or an alternate provider.

Each MCO is required to systematically, and regularly, verify covered services furnished by PCPs meet the 24/7 access criteria and to enforce accessibility standards if providers are found to be non-compliant. MCOs also survey providers on a quarterly, semiannual, or annual basis to assess compliance with the 24/7 and after-hours provider accessibility requirements. MCOs utilize methods including computer-assisted telephone interviews, telephone surveys (non-computerized), mailed surveys, monthly secret shopper calls, and face-to-face provider visits in order to measure provider accessibility compliance with HHSC contractual standards. Provider compliance rates with 24/7 accessibility ranged from 8.00% to 100%. Providers who are not in compliance with HHSC's contractual standards receive phone calls or letters detailing the contractual requirements and are subject to remediation methods including provider re-education letters outlining the managed care contractual standards, follow-up surveys, face-to-face re-education (e.g. evaluating/coaching provider staff, provider trainings) and unscheduled calls to providers to reassess compliance. MCOs employ contractual remedies for providers 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 SFY20. The survey results are as follows: STAR program provider compliance was 31% in accessibility and 43% in language, STAR Kids program provider compliance was 46% in accessibility and 79% in language, and STAR+PLUS program provider compliance was 27% in accessibility and 43% in language.

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. PCP network access ensures PCP access within the distance standard of 90% of two providers. All MCOs met PCP network access standards for the STAR, STAR+PLUS and STAR Kids programs for SFY20 Q4.

Attachment H2 (included in Attachment H) displays specialty provider analysis by program and county designation. Specialist network access ensures specialty provider access within the distance standard of 90% of one provider for each specialty provider. The specialty providers include audiologist, behavioral health outpatient; cardiovascular disease; ear, nose and throat (ENT), Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR), nursing facility, OB/GYN, ophthalmologist, orthopedist, pediatric sub-specialty, prenatal care, psychiatrist, therapy (occupational, physical, and speech), and urologist.

Data for Q1 and Q2 were revised to reflect standards for "Members Within Distance Standard of Two Providers" to "Members Within Distance Standard of One Provider" for Specialist and Dental Specialist. The standard for distance within two providers is for PCP and Main Dentist. The standard for one

provider is specialist and dental specialist. Effective 9.1.2020, HHSC amended the standards to two providers across the board for SFY21.

The following MCOs did not maintain sufficient specialty providers in SFY20 Q4:

Audiologist

- STAR
 - Metro – Cook Children’s Health Plan, FirstCare, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children’s Health Plan,
 - Micro – Amerigroup, Cook Children’s Health Plan, Driscoll Health Plan, FirstCare, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural – Amerigroup, FirstCare, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
- STAR+PLUS
 - Metro – Cigna-HealthSpring, Superior HealthPlan, and UnitedHealthcare Community Plan.
 - Micro – Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
 - Rural – Amerigroup, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR Kids
 - Metro – Cook Children’s Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Micro – Cook Children’s Health Plan, 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.

Behavioral Health – Outpatient

- STAR
 - Metro – FirstCare and Texas Children’s Health Plan.
 - Micro – Cook Children’s Health Plan and Texas Children's Health Plan.
 - Rural – FirstCare and Texas Children’s Health Plan.
- STAR Kids
 - Micro – Cook Children’s.

Cardiovascular Disease

- STAR
 - Metro – Cook Children’s Health Plan, FirstCare and Texas Children’s Health Plan.

- Micro – Cook Children’s Health Plan, Molina Healthcare of Texas, Texas Children’s Health Plan and UnitedHealthcare Community Plan.
- Rural – FirstCare and Texas Children’s Health Plan.
- STAR+PLUS
 - Micro – Molina Healthcare of Texas.
- STAR Kids
 - Metro – Blue Cross and Blue Shield of Texas and Cook Children’s Health Plan.
 - Micro – Blue Cross and Blue Shield of Texas, Cook Children's Health Plan and Superior HealthPlan.

ENT (Otolaryngology)

- STAR
 - Metro – FirstCare, Right Care from Scott and White Health Plans, and Texas Children’s Health Plan.
 - Micro – Driscoll Health Plan, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Texas Children’s Health Plan, and UnitedHealthcare Community Plan.
 - Rural – FirstCare, Right Care from Scott and White Health Plans, and Texas Children’s Health Plan.
- STAR+PLUS
 - Micro – Molina Healthcare of Texas.
- STAR Kids
 - Micro – Driscoll Health Plan.
 - Rural – Amerigroup.

Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR)

- STAR
 - Metro – Cook Children’s Health Plan, Driscoll Health Plan, FirstCare, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Texas Children’s Health Plan, and UnitedHealthcare Community Plan.
 - Micro – Aetna Better Health, Amerigroup, Blue Cross Blue Shield, Community First Health Plans, Community Health Choice, Cook Children's Health Plan, Dell Children's Health Plan, Driscoll Health Plan, FirstCare, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural – Amerigroup, Driscoll Health Plan, FirstCare, Right Care from Scott and White Health Plans, Superior HealthPlan, and Texas Children’s Health Plan.
- STAR+PLUS
 - Metro – Cigna-HealthSpring, Molina Healthcare of Texas, and UnitedHealthcare Community Plan.
 - Micro – Amerigroup, Cigna-HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and UnitedHealthcare Community Plan.

- Rural – Amerigroup, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR Kids
 - Metro – Aetna Better Health, Cook Children’s Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Micro – Aetna Better Health, Blue Cross Blue Shield of Texas, Community First Health Plans, Cook Children’s Health Plan, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural –Amerigroup, Blue Cross Blue Shield of Texas, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

OB/GYN

- STAR
 - Metro – FirstCare and Texas Children’s Health Plan.
 - Micro - Texas Children’s Health Plan.
 - Rural – FirstCare and Texas Children’s Health Plan.

Ophthalmologist

- STAR
 - Metro – Cook Children’s Health Plan, FirstCare and Right Care from Scott and White Health Plans.
 - Micro – Amerigroup, Cook Children's Health Plan, FirstCare, Molina Healthcare of Texas, and UnitedHealthcare Community Plan.
 - Rural – FirstCare.
- STAR+PLUS
 - Micro – Cigna-HealthSpring and UnitedHealthcare Community Plan.
- STAR Kids
 - Metro – Cook Children’s Health Plan.
 - Micro – Cook Children's Health Plan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural – Superior HealthPlan.

Orthopedist

- STAR
 - Metro – Cook Children’s Health Plan, FirstCare and Texas Children's Health Plan.
 - Micro – Cook Children's Health Plan, Molina Healthcare of Texas, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural – FirstCare and Texas Children's Health Plan.
- STAR+PLUS
 - Micro – Amerigroup and Molina Healthcare of Texas.
 - Rural – Amerigroup.
- STAR Kids

- Metro – Cook Children’s Health Plan.
- Micro – Cook Children's Health Plan.

Pediatric Sub-Specialty

- STAR
 - Metro – Community First Health Plans, Cook Children’s Health Plan, FirstCare, Texas Children's Health Plan.
 - Micro – Amerigroup, Community First Health Plans, Cook Children's Health Plan, Molina Healthcare of Texas, Superior Health Plan, and Texas Children's Health Plan.
 - Rural – Amerigroup, Community First Health Plans, and Texas Children's Health Plan.
- STAR Kids
 - Metro – Community First Health Plans and Cook Children's Health Plan.
 - Micro – Amerigroup, Community First Health Plans, Cook Children's Health Plan, Superior HealthPlan, and Texas Children's Health Plan.
 - Rural –Amerigroup, Community First Health Plans, and Superior HealthPlan.

Prenatal

- STAR
 - Metro – Cook Children’s Health Plan and Texas Children's Health Plan.
 - Micro – Cook Children’s Health Plan and Texas Children's Health Plan.
 - Rural - El Paso First, FirstCare, and Texas Children's Health Plan.
- STAR Kids
 - Metro – Cook Children’s Health Plan.
 - Micro – Cook Children’s Health Plan.

Psychiatrist

- STAR
 - Metro – Driscoll Health Plan, FirstCare, and Texas Children's Health Plan.
 - Micro – Driscoll Health Plan, FirstCare, Molina Healthcare of Texas, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural – FirstCare, Superior HealthPlan, and Texas Children's Health Plan.
- STAR+PLUS
 - Micro – Molina Healthcare of Texas and Superior HealthPlan.
 - Rural – Superior HealthPlan.
- STAR Kids
 - Metro – Driscoll Health Plan.
 - Micro – Driscoll Health Plan and Superior HealthPlan.
 - Rural – Blue Cross and Blue Shield of Texas and Superior HealthPlan.

Therapy (Occupational, Physical, and Speech)

- STAR
 - Metro – Texas Children's Health Plan.

- Micro – FirstCare and Texas Children's Health Plan.
- Rural – FirstCare and Texas Children's Health Plan.

Urologist

- STAR
 - Metro – FirstCare, Right Care from Scott and White Health Plans and Texas Children's Health Plan.
 - Micro – Community Health Choice, Cook Children's Health Plan, Molina Healthcare of Texas, Right Care from Scott and White Health Plans, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
 - Rural – Amerigroup, Community Health Choice, FirstCare, Right Care from Scott and White Health Plans, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.
- STAR+PLUS
 - Rural – Amerigroup, Superior HealthPlan, and UnitedHealthcare Community Plan.
- STAR Kids
 - Micro – Cook Children's Health Plan.
 - Rural – Amerigroup, Superior HealthPlan, and UnitedHealthcare Community Plan.

The DMOs (DentaQuest and MCNA) met the network access standard throughout SFY20. ***Attachment H under the page titled H3*** provides dentist analysis by DMO and county designation.

Access to dental specialty providers, Orthodontist and Pediatric Dental, was limited in micro and rural county types across the state for Q3. DentaQuest met the standards for Pediatric Dental but MCNA Dental did not. ***Attachment H under the page titled H4*** provides dental specialty analysis by provider type and county designation.

Network Adequacy Standard Exceptions

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 are under corrective action for network adequacy, HHSC is focusing its monitoring efforts ensuring implementation strategies of access to care plans and member education initiatives.

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.

The MCCO Network Adequacy team identified discrepancies with the provider network file validation process conducted by MAXIMUS for the P92 PCP Network File, P94 Specialist Network file and the P020 Monthly Provider file that impacted the alternate addresses being reported. The reporting inaccuracies led to the MCCO Network Adequacy team's Corrective Action Plan (CAP) process being put on hold by MCS leadership after Q2 SFY19. CAPs issued for Q4 SFY18 and Q2 SFY19 were closed. The validation process has been updated and was put into production March 2020. The MCCO Network Adequacy team will resume distribution of the Quarterly Performance Reports that capture overall network performance for each MCO/DMO effective Q4 SFY20. MCOs/DMOs will use Q4 SFY20 and Q1 SFY21 reports to address any discrepancies as CAP Requests capturing non-compliances will resume Q2 SFY21.

Access to Pharmacy

MCOs are required to provide pharmacy access to members in each service delivery area (SDA) within the contractual performance standards. Effective SFY19, the performance standards changed as follows:

For counties included in the Medicaid Rural Service Area (MRSA), the following standards apply to STAR:

- In a Metro County, at least 75% of Members must have access to a Network Pharmacy within 2 miles or 5 minutes of the Member's residence
- In a Micro County, at least 55% of Members must have access to a Network Pharmacy within 5 miles or 10 minutes of the Member's residence
- In a Rural County, at least 90% of Members must have access to a Network Pharmacy within 15 miles or 25 minutes of the Member's residence; and
- At least 90% of Members must have access to a 24-hour pharmacy within 75 miles of the Member's residence.

For all other counties and Programs, the following standards apply:

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

Attachment J details the Geo-distance results for SFY20 Q1 and Q3. The Q2 SFY 2020 results for pharmacy have not been published as overall results are not reliable due to a data transmission and verification glitch. HHSC was able to remedy the issue for Q3; however, there are no remedial actions for Q2 data errors. The Q4 SFY20 results for pharmacy are still under construction and require validation by HHSC and will be available to report in a future monitoring report.

The following MCOs did not meet all pharmacy access performance standards in SFY20 Q3:

- STAR MRSA
 - Metro – Right Care from Scott and White Health Plans and FirstCare.
 - Micro – FirstCare.
 - Rural – Amerigroup.
- STAR All Other Counties:
 - Metro – Molina Healthcare of Texas, UnitedHealthcare Community Plan, and FirstCare.
 - Micro – Molina Healthcare of Texas, Driscoll Health Plan, Superior HealthPlan and UnitedHealthcare Community Plan.
 - Rural – Driscoll Health Plan, El Paso Health, FirstCare Molina Healthcare of Texas, Community Health Choice Superior HealthPlan, Texas Children's Health Plan and UnitedHealthcare Community Plan.
- STAR Kids
 - Metro – Superior HealthPlan and UnitedHealthcare Community Plan.
 - Micro – Driscoll Health Plan, Superior HealthPlan and UnitedHealthcare Community Plan.
 - Rural – Amerigroup, Driscoll Health Plan, Superior HealthPlan, Texas Children's Health Plan, and UnitedHealthcare Community Plan.

No data was provided from STAR+ PLUS MCOs because the capitation rates do not include the costs of Medicaid wrap-around services for outpatient drugs and biological products for STAR+PLUS Members. HHSC makes supplemental payments to the MCO for these Medicaid wrap-around services based on encounter data received by HHSC's Administrative Services Contractor during an encounter reporting period.

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 an Open Panel at an 80% benchmark. In SFY20 Q4, all MCOs and DMOs, except Cook Children's in STAR (73.46%) and STAR Kids (71.64%) met the 80% benchmark. 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-network. Based on these justifications, HHSC is not pursuing remedial action against Cook Children's.

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.

Due to the public health emergency, HHSC waived the OON requirements for Q3 and Q4 2020.

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.

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 anticipates the following change in benefits.

Autism Services

The 2020-21 Texas General Appropriations Act (Rider 32, Article II, House Bill (HB) 1) authorized the implementation of additional services for the treatment of eligible children with autism under the Texas Medicaid program. HHSC plans to submit 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).

Service Utilization

Attachment S illustrates enrollment and expenditures by program and claim type for SFY19, covering September 1, 2018 through August 31, 2019. The total spending in STAR, STAR+PLUS, and STAR Kids in SFY18 included:

- Professional claims: 36.47%

- Outpatient claims: 23.41%
- Drug claims: 16.23%
- Inpatient claims: 18.86%
- Dental claims: 5.03

Medicaid Managed Care

Medical Transportation Managed Care Carve-in - House Bill (HB) 1576

House Bill (H.B.) 1576, 86th Legislative Session, directs HHSC to require managed care organizations to provide non-emergency medical transportation services, a subset of demand response transportation services, for certain trips requested with less than a 48-hour notice. The bill further transfers coordination of non-emergency medical transportation (NEMT) services from managed transportation organizations (MTOs) to the Medicaid managed care organizations (MCOs) responsible for coordinating medical services. Beginning January 17, 2020, certain MCOs began piloting the delivery of the expanded demand response transportation services using value-added services. HHSC is planning for a June 2021 implementation date for the full carve in of NEMT into managed care. Impacted 1115 programs include STAR, STAR+PLUS, and STAR Kids. The NEMT 1115 Amendment was submitted in January 2021.

Medically Fragile Individuals – House Bill (HB) 4533

House Bill (H.B.) 4533, SECTION 32, 86th Legislature, Regular Session, 2019 requires HHSC to pursue a benefit for medically fragile individuals. If determined to be cost effective, HHSC plans to submit an amendment to add this benefit to the 1115 Transformation waiver under the STAR+PLUS Home and Community Based Services (HCBS) program. HHSC submitted this amendment to CMS initially on September 1, 2020. HHSC submitted the packet again on February 22, 2021 and included additional information to meet CMS transparency requirements.

Long-Term Services and Supports for Individuals with Intellectual and Developmental Disabilities (IDD) Transition – House Bill (HB) 4533

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 in accordance with implementation/effective dates as published in the Federal Register or guidance pertaining to the HCBS settings rule. HHSC continues to work on various aspects of compliance, including rule revisions and updates to managed care guidance documents. Over the next year HHSC will continue work on this initiative, which includes seeking CMS approval of the Texas Statewide Transition Plan.

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. Currently, data for SFY20 are still pending MCO corrections due to the switch to TexConnect and changes in deliverables. The transition to the TexConnect Portal required MCOs to make system modifications to generate reporting in a text file submission format rather than complete an Excel spreadsheet and enhance the information provided to include member and/or provider specific data. Significant changes to the complaints reporting caused several MCOs to raise concerns. HHSC heeded these concerns as valid and implemented a soft launch for six months before HHSC would consider remedies for non-compliance. SFY20 data for the Complaints and Appeals section received by MCOs is in the process of revalidation for all quarters. HHSC requested MCO’s to re-submit Appeals and Complaints data for all quarters. HHSC will report this data in the next monitoring report.

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 (MCSN) to better coordinate assistance provided to Medicaid managed care clients as mandated by the state legislature. The network of entities includes the Ombudsman Office, the Long-Term Care Ombudsman, the HHSC Medicaid/CHIP Division, Aging & Disability Resource Centers (ADRCs), and Area Agencies on Aging.

Overall OMCAT and MCCO complaints in SFY20 Q3 were 1,510 and in SFY20 Q4 1,899. ***Attachment O*** provides complaints performance summary.

OMCAT received a total of 668 complaints in SFY20 Q3 showing a 19% increase in complaints as compared to SFY20 Q4 at 798 total complaints. The percentage of change, by each program, between SFY20 Q3 and SFY20 Q4 is as follows: STAR (16% increase), STAR+PLUS (15% increase), STAR Kids (13% increase), and Dental (194% increase). The top three complaint categories for OMCAT complaints in SFY20 Q4 were access to care, prescription services, and claims/payment.

MCCO received a total of 11 legislative complaints in SFY20 Q3 showing a 36% decrease compared to the SFY20 Q4 with 7 complaints. The percentage of change, by each program, between SFY20 Q3 and SFY20 Q4 is as follows: STAR (no change) STAR+PLUS (60% decrease), and STAR Kids (50% decrease). The dental program had zero complaints in SFY20 Q3 and Q4. The primary reason for legislative complaints in SFY20 Q4 was denial or delay of payment.

MCCO received a total of 306 member complaints in SFY20 Q3 with a 2% increase as compared to SFY20 Q4 at 313 total complaints. The percentage of change, by each program, between SFY20 Q3 and SFY20 Q4 is as follows: STAR (60% increase), STAR+PLUS (27% decrease), and STAR Kids (18% increase). The dental program received 1 complaint in SFY20 Q3 and 6 complaints in SFY20 Q4 (500% increase). The top three reasons for member complaints in SFY Q4 were utilization review referrals, denial of claim, and member enrollment issues.

MCCO received a total of 525 provider complaints in SFY20 Q3 with a 49% increase as compared to SFY20 Q4 at 781 total complaints. The percentage of change, by program, between SFY20 Q3 and SFY20 Q4 is as follows: STAR (82% increase), and STAR+PLUS (20% increase), STAR Kids (72% increase). The Dental program had a 78% increase receiving 9 complaints in SFY20 Q3 and 16 complaints in SFY20 Q4. The top three reasons for provider complaints in SFY Q4 were denial of claim, denial or delay of payment, and payment dispute.

Provider Fraud and Abuse

MCOs and DMOs are required to send referrals regarding Medicaid waste, abuse, or fraud to the HHSC Office of Inspector General (OIG). Please see ***Attachments R1 and R2*** for MCO and DMO provider referral details. The OIG received a total of 92 fraud and abuse referrals from MCOs in SFY20 Q3 and 91 in SFY20 Q4. These attachments reflect the current status of each case and these cases can have multiple dispositions; therefore, the disposition total will not add up to the total number of referrals received.

The OIG received a total of 14 fraud and abuse referrals from DMOs in SFY20 Q3 and 8 in SFY20 Q4.

Hotline Performance

SFY20 data for Hotline performance is in the process of revalidation for Q3 and Q4. HHSC requested MCO's re-submit Hotline data for Q3 and Q4. HHSC will report this data in a future monitoring report.

Attachment M outlines performance standards of MCO and DMO Member and Provider Hotlines for Q1 and Q2, which was provided in the semiannual report.

- 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.

MCOs have been instructed to aggregate totals by program and hotline type for all their STAR, CHIP and STAR+PLUS plans. Because MCOs expressed concerns that the average hold time was not being calculated correctly, MCOs will begin submitting the total hold time as of 9/1/2020. HHSC will use the total hold time values to calculate the average hold time on the back end to monitor MCO compliance. Due to this change HHSC will not produce any breakout by STAR, CHIP or STAR+PLUS alone for any MCO. CHIP and Medicaid Dental within the same DMO are also aggregated. HHSC will also no longer provide a breakout by SDA due to reporting changes and TexConnect data.

At this time the TexConnect deliverables report separates data based on in-house and individual subcontracted call centers. HHSC is working to get information on how MCO's calculate "Average Hold Time" in order to aggregate the in-house and subcontracted call center figures for that measure. The TexConnect deliverables for hotlines no longer collect "Call Pickup Rate" nor "Busy Signal Rate." HHSC began reporting these measures again on September 1, 2020 and plans to include the data in the next monitoring report.

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.

The impact of the public health emergency on quality measures is expected to be significant due to members delaying or avoiding preventive and primary care. There is also the potential for emergency department utilization to increase. Due to these impacts,

- HHSC is unable to compare 2020 quality measure performance, and the benchmarks established based on the prior year's performance, to last year's performance. Therefore, for calendar year 2020 the medical and dental Pay-for-Quality (P4Q) programs will be suspended. No premium recoupments or distributions will occur based on calendar year 2020 performance.
- MCOs had difficulty obtaining enough medical records from providers to meet the minimum sample requirement for Encounter Data Validation (EDV). Texas requires HHSC to use the External Quality Review Organization (EQRO) EDV deliverable to monitor both MCOs and DMOs. HHSC now requires MCOs to meet a minimum sample size of medical records with a 90% compliance rate on the data collected and reviewed from those records. MCOs that do not meet one or both requirements are subject to CAPs. For measurement year 2020, CAPs will be replaced with Plans of Action, which are the lowest level of contract remediation.
- HHSC adjusted the 1115 evaluation design measure 3.5.2. The study's technical specifications were updated to exclude the adult Adoption Assistance (AA)/Permanency Care Assistance (PCA) population due to the small number of AA and PCA clients meeting the age criteria for the corresponding Adult survey. The 1115 evaluation will continue to report customer satisfaction outcomes for AA/PCA and Medicaid for Breast and Cervical Cancer (MBCC) populations, with AA/PCA reported from Consumer Assessment of Healthcare Providers and Systems (CAHPS), STAR Child surveys (2019, 2021), and MBCC reported from CAHPS STAR+PLUS surveys (2020, 2022).
- HHSC extended active performance improvement projects (PIPs) for an additional year.

Another change is occurring. Based on the EQRO's comparative analysis of changes to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications for the prenatal and postpartum care measure, HHSC is using administrative rates for the HEDIS 2020 PPC prenatal sub-measure, which is a departure from prior years where the hybrid specifications were used.

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.

DY9 Q3 April – June 2020
 Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Apr 2020)	Month 2 (May 2020)	Month 3 (Jun 2020)	Total for Quarter Ending 6/2020
Adults	290,400	309,043	326,956	926,398
Children	2,625,182	2,683,839	2,737,721	8,046,742
AMR	355,283	356,118	357,330	1,068,731
Disabled	405,156	407,167	408,982	1,221,305

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Apr 2020)	Month 2 (May 20120)	Month 3 (Jun 2020)	Total for Quarter Ending 6/2020
Foster Care	34,462	35,225	36,021	105,707
Medically Needy	104	114	131	348
CHIP-Funded	262,602	267,524	270,207	800,333
STAR+PLUS 217-Like HCBS	18,718	18,512	18,425	55,655

DY9 Q4 July – September 2020
 Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Jul 2020)	Month 2 (Aug 2020)	Month 3 (Sep 2020)	Total for Quarter Ending 9/2020
Adults	343,065	359,375	388,147	1,090,587
Children	2,790,476	2,850,531	2,942,031	8,583,038
AMR	357,764	358,833	359,623	1,076,220

Disabled	410,562	412,689	413,533	1,236,785
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Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Jul 2020)	Month 2 (Aug 2020)	Month 3 (Sep 2020)	Total for Quarter Ending 9/2020
Foster Care	36,952	38,190	38,923	114,065
Medically Needy	123	122	122	367
CHIP-Funded	273,711	280,353	289,710	843,774
STAR+PLUS 217-Like HCBS	18,449	18,479	18,687	55,616

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.

Procurement Activities

HHSC has created a plan to procure new contracts for STAR+PLUS, STAR, and STAR Kids and will be proceeding in that order. Estimated timelines are:

Star Plus

- RFP Posting: Q2 FY2022
- Estimated Notice of Award: Q3 FY2022
- Start of Operations: Q1 FY2024

Star

- RFP Posting: Q1 FY2023
- Estimated Notice of Award: Q2 FY2023
- Start of Operations: Q4 FY2024

Star Kids

- RFP Posting: Q3 FY2023
- Estimated Notice of Award: Q4 FY2023
- Start of Operations: Q2 FY2025

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 (SFY20 Q4 Month 3)

Acute Care Claims

% Appealed Adjudicated within 30 Days (98% STD)

- Aetna
- Parkland

STAR Kids (SFY20 Q4 Month 3)

Acute Care Claims

% Appealed Adjudicated within 30 Days (98% STD)

- Aetna

Long-term Services and Supports Claims

% Appealed Adjudicated within 30 Days (98% STD)

- Aetna

Litigation Summary

Consideration 1:

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

Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY8: October 1, 2019 – September 30, 2020
State Fiscal Year FY20: September 1, 2019 – August 31, 2020
Submitted on March 1, 2021

	<p>order, and the related consent decree paragraphs. One toll-free number remains under the corrective action order and court monitoring.</p> <p>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."</p> <p>On April 7, 2020, the district court entered an order addressing provider "shortages" based on the Fifth Circuit's decision and denying the defendants' motion to reinstate the order vacating those portions of the Corrective Action Order.</p>
Date and Report in Which Consideration Was First Reported	The lawsuit was filed on September 1, 1993. The consent decree was entered on February 20, 1996. The eleven corrective action orders were entered on April 27, 2007.
Summary of Impact	The consent decree and corrective action orders touch upon many program areas, and generally require the state to take actions intended to ensure access, or measure access, to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons under age 21.
Estimated Number of Beneficiaries	Estimated (as of March 2020) at 3,008,214.
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

Health Information Exchange (HIE) Connectivity Project Update

The HIE Connectivity Project is a Texas Medicaid initiative funded by CMS through the HIE Implementation Advance Planning Document (IAPD). The project's three strategies, one initiative, and associated goals/milestones were described in the Health Information Technology (HIT) Strategic Plan approved by CMS in May of 2020. Successful implementation of the three strategies will result in increased HIE adoption and use by Medicaid providers, creation of new HIE capacity in Texas, and bring clinical information into the Texas Medicaid program through HIE. The following is an update regarding progress made for each strategy, as well as the Patient Unified Lookup System for Emergencies (PULSE) initiative.

HIE IAPD Strategies 1-3

The FFY 2020/2021 milestone for Strategy 1 of the HIE Connectivity Project, as listed in the HIT Strategic Plan, is two hundred Medicaid providers (including hospitals and ambulatory providers) connected to Local HIEs. Currently, three Local HIEs have contracted with HHSC to onboard and connect Medicaid providers and hospitals. These connections will facilitate electronic reporting and data exchange between providers and Texas Medicaid. As of 12/11/20, 161 providers from hospitals and ambulatory practices have been approved, through this project, to join with the three Local HIEs.

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

Strategy 3 assists Texas Medicaid in reducing emergency department (ED) utilization and hospital readmissions by enabling better follow-up care through the electronic receipt of Health Level Seven (HL7) Admission, Discharge, Transfer (ADT) data from hospitals. The FFY 2020/2021 milestone for this strategy, as listed in the HIT Strategic Plan, was for eight Local HIEs to contribute hospital emergency department ADT data as an outcome of this project. Currently, one of the three Local HIEs contracted through Strategy 1 has successfully transferred ADT data in near real-time.

PULSE (Initiative 1)

HHSC is working with THSA to implement the PULSE Initiative. Texas wants to improve its ability to provide patient medical information to qualified first responders during state and federal disasters, and is building PULSE software, infrastructure, and connectivity to HIEs. The FFY 2020/2021 milestone for this initiative, as described in the HIT Strategic Plan, is to develop a plan and the PULSE application, as well as to test and launch the application and implement the program. In August 2020, THSA began development of the HIE Texas PULSE system in partnership with Audacious Inquiry. The PULSE COVID system is currently in operation and will continue for the remainder of the 2020 hurricane season, after which the system will be upgraded to the PULSE Enterprise Edition (PULSE EE). PULSE EE will provide other capabilities, including additional user capacity, improved operational reporting, and integration with push data sources to support integrated family reunification. It requires additional software and infrastructure build-out and is currently in development.

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 during SFY20 Q3:

- HHSC held a quarterly meeting with the Principal Investigator from Texas A&M University (TAMU) on March 2, 2020.
- HHSC analysts completed and transferred ad hoc data requests to TAMU.
- HHSC analysts provided data-related technical assistance as requested by TAMU.
- HHSC submitted an amendment to the CMS-approved 1115 evaluation design on March 10, 2020. The submitted amendment updated the populations surveyed by Consumer Assessment of

Healthcare Providers and Systems (CAHPS) each year for measure 3.5.2. CMS approved the amendment to the evaluation design on March 10, 2020. HHSC submitted the updated evaluation plan, including the approved amendment, to CMS on March 26, 2020.

- TAMU submitted proposed revisions to the DSRIP claims analyses to HHSC on April 21, 2020 (Measures 1.2.1 –1.2.4). The proposed revisions attempted to resolve analytic challenges resulting from an inability to generate a balanced comparison group of Medicaid clients visiting non-DSRIP providers. HHSC reviewed and met with TAMU to discuss their proposed revisions to DSRIP claims analyses. TAMU was still finalizing their proposed revisions based on feedback from HHSC at the end of SFY20 Q3.
- HHSC analysts prepared a narrative describing how the 1115 evaluation design may be modified to incorporate an 1115 waiver amendment allowing children and young adults in Adoption Assistance or Permanency Care Assistance greater flexibility in their choice of Medicaid managed care program. HHSC submitted the 1115 waiver amendment shortly after SFY20 Q3 ended (June 2, 2020).

HHSC completed the following 1115 Waiver evaluation activities during SFY20 Q4:

- HHSC held a quarterly meeting with the Principal Investigator from Texas A&M University (TAMU) on August 27, 2020.
- HHSC analysts completed and transferred ad hoc data requests to TAMU.
- HHSC analysts provided data-related technical assistance as requested by TAMU.
- TAMU submitted proposed revisions to the DSRIP claims analyses to HHSC on April 21, 2020 (Measures 1.2.1 –1.2.4). The proposed revisions attempt to resolve analytic challenges resulting from an inability to generate a balanced comparison group of Medicaid clients visiting non-DSRIP providers. HHSC reviewed and met with TAMU in June 2020 to discuss their proposed revisions to DSRIP claims analyses. TAMU was still finalizing their proposed revisions based on feedback from HHSC at the end of SFY20 Q4.
- HHSC analysts prepared a narrative describing how the 1115 evaluation design may be modified to incorporate an 1115 waiver amendment seeking Medicaid managed care coverage of benefits for medically fragile individuals whose service needs exceed the cost limits of the STAR+PLUS Home and Community Based Services program. HHSC submitted the 1115 waiver amendment shortly after SFY20 Q4 ended (September 1, 2020).
- HHSC submitted a five-part pre-post implementation study of STAR Kids conducted by Texas’s External Quality Review Organization (EQRO), and a summary document detailing overlap between CMS-approved evaluation measures and the EQRO deliverables, to CMS on August 13, 2020. HHSC is seeking CMS approval to use the EQRO STAR Kids study to satisfy evaluation components related to managed care expansion among the STAR Kids population, as proposed in the original 1115 evaluation design. CMS approval related to use of the EQRO STAR Kids study was still pending at the end of SFY20.

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

Medicaid Section 1115 Monitoring Report
 Texas Healthcare Transformation and Quality Improvement Program
 Demonstration Year DY8: October 1, 2019 – September 30, 2020
 State Fiscal Year FY20: September 1, 2019 – August 31, 2020
 Submitted on March 1, 2021

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Procurement of Independent External Evaluator	9/1/2019	<i>The contract with TAMU has been executed and initial funds dispersed.</i>	<i>No issues anticipated at this time</i>
Interim Evaluation Report	9/30/2021 <i>(or upon application for renewal)</i>	<i>TAMU is not able to generate a balanced comparison group for DSRIP claims analysis; alternate analytic strategies are being explored.</i>	<i>No issues anticipated at this time</i>
Summative Evaluation Report	3/30/2024		<i>No issues anticipated at this time</i>

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.

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 from DY1-6 to DY7-10. DSRIP providers report on required categories at the provider system level, rather than the project level. Regional Healthcare Partnerships (RHP) updated their RHP Plans during Q1, which HHSC reviewed and approved. This included providers updating their outcome measures and activities for reporting during DY9-10.

Medicaid Section 1115 Monitoring Report
Texas Healthcare Transformation and Quality Improvement Program
Demonstration Year DY8: October 1, 2019 – September 30, 2020
State Fiscal Year FY20: September 1, 2019 – August 31, 2020
Submitted on March 1, 2021

Providers continued to report performance achievement of DY7 and DY8 Category C measures and DY9 Category D measures in April 2020. In total for April DY9 reporting and based on available Intergovernmental Transfer (IGT), \$2,366,701,655 was paid for DSRIP in July 2020, for a total of \$19.3 billion in DY1-9 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 DY9 reporting. **Attachment Y** provides estimated remaining payments for DY8-9.

In April DY9 (DY9R1), 2,363 Category C measures were eligible to report Performance Year 2 (PY2, which is 01/01/19 – 12/31/19) to potentially earn payment for the DY8 achievement milestone. Overall, 75.6% of measures eligible to report achievement were reported in April 2020 as fully achieving the DY8 goal in PY2, and an additional 10.5% of measures reported partially achieving the DY8 goal in PY2. Of the 81 measures newly selected for DY9-10, 71.6% reported baseline in April 2020. The remaining 242 Category C measures are eligible to report PY2 in October 2020. For DY7 carried forward measures, 55.6% reported as fully achieving the DY7 goal in PY2 during April 2020 reporting, and an additional 10.9% of measures reported partially achieving the DY7 goal in PY2. 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.

<i>Measure Type</i>	<i>P4P Measures Eligible to Report in DY9R1</i>	<i>P4P Measures that have reported PY2 (CY19) in DY9R1</i>	<i>Carryforward P4P 100% of AM-7.x Goal Achieved in PY2</i>	<i>Carryforward P4P Partial Achievement of AM-7.x Goal in PY2</i>	<i>Carryforward P4P 0% of AM-7.x Goal Achieved in PY2</i>	<i>P4P 100% of AM-8.x Goal Achieved in PY2</i>	<i>P4P Partial Achievement of AM-8.x Goal in PY2</i>	<i>P4P 0% of AM-8.x Goal Achieved in PY2</i>
<i>Cancer Screening</i>	111	98%	53.60%	25.00%	21.40%	76.10%	13.80%	10.10%
<i>Clinical Outcome</i>	510	92.50%	50.00%	4.60%	45.40%	68.20%	12.30%	19.50%
<i>Hospital Safety</i>	234	78.80%	39.00%	1.30%	59.70%	53.80%	8.20%	37.90%
<i>Immunization</i>	250	91.70%	69.40%	8.20%	22.40%	73.80%	16.30%	9.90%
<i>Population Based Clinical Outcome</i>	111	90.20%	29.30%	4.90%	65.90%	56.40%	7.90%	35.60%
<i>Process</i>	1331	92.00%	64.30%	16.40%	19.30%	83.50%	8.80%	7.60%
<i>Quality of Life</i>	19	100.00%	NA	NA	NA	63.20%	21.10%	15.80%
<i>All Measures</i>	2363	91.10%	55.60%	10.90%	33.50%	75.60%	10.50%	13.90%

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

DSRIP Transition Plan Update

As required, HHSC submitted its Transition Plan to CMS by October 1, 2019, and submitted revisions to CMS on February 20, 2020. Due to the public health emergency, CMS offered HHSC the opportunity to amend milestone deliverable due dates. In early August 2020, HHSC requested approval from CMS of new due dates for Transition Plan milestone deliverables. CMS approved the Transition Plan with the amended deliverable due dates on September 2, 2020.

To help Texas sustain DSRIP successes, HHSC completed comprehensive analyses of populations served by DSRIP and interventions associated with improvements in health outcomes within focus areas of the Transition Plan. HHSC has engaged stakeholders and invited input through surveys about telehealth,

advancing value-based payments, the regional healthcare partnership structure of the program, and quality improvement cost guidelines. Data from these surveys will contribute to assessments of these topic areas and relevant policy development. HHSC also created a Best Practices Workgroup of current DSRIP stakeholders to inform transition work through additional data support and expertise. HHSC has used information from this workgroup and provider-specific feedback to craft program options for DY 11 and beyond. HHSC has also contracted for studies regarding social determinants of health, their impact on health care quality measures, findings from environmental scans, and policy considerations from experts in the field.

HHSC has held three quarterly Partner Engagement and Executive Waiver Committee meetings and provided monthly updates to keep all interested stakeholders informed on the transition progress. Texas submitted its first two deliverables under the Transition Plan to CMS at the end of December 2020.

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.

HHSC hosted a public forum via webinar on June 22, 2020 to provide the public with updates on the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 waiver. The previous public forum was held on June 24, 2019 and was conducted in person. The date, time, and location of the public forums were published on HHSC's website 30 days in advance of the meetings.

During the June 2020 public forum the public was provided with an update on the following Transformation waiver topics: Health Information Technology (IT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, and Nursing Home Quality Incentive Payment Program. Links to the 1115 DY8 annual report and COVID-19 resource pages was also provided to the public. Public comment was also received and documented at this meeting. Comments received related to identifying external entities involved in the Health IT strategies, the process for creating new Medicaid benefits or programs, DSRIP operations and extension of DSRIP program, Value Based Purchasing, Uncompensated Care pool payments, and the potential to request an extension in light of COVID-19 as some other states are also doing. Requests for the PowerPoint

presentation were received from some stakeholders and the slide deck was provided to those individuals electronically. During the forum, HHSC responded to comments and clarifying questions received.

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 (SFY20). The attachment includes annual and quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.

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

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

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

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

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

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.

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.

Attachments V1-V4 - Claims Summary (SFY 2019). 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.