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

As Required by

Special Terms and Conditions 74

and 42 CFR § 431.428

Texas Health and Human Services

Commission

Q4 & Annual Report

December 2023

TEXAS
Health and Human Services

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1. Preface

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

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

2. Executive Summary

According to the Special Terms and Conditions (STCs) of the Demonstration, the Texas Health and Human Services Commission (HHSC) provides the quarter four and annual monitoring report for Demonstration Year (DY) 12, which began October 1, 2022[1]. Pursuant to 42 CFR § 431.428, Texas provides this quarterly and annual report to demonstrate how the goals and objectives were met as Texas Medicaid served over five million Medicaid beneficiaries through risk-based Medicaid managed care authorized under this waiver while finalizing the transition from the Delivery System Reform Incentive Payment (DSRIP) pool to integrated directed payment programs, continuing the Uncompensated Care (UC) pool, and launching the Public Health Provider Charity Care Program.

Growth in Caseload

As of September 2023, Texas had over 5.0 million full benefit clients in Medicaid.[2] Prior to the federal COVID-19 public health emergency (PHE), full benefit caseloads were under 4 million and experiencing overall declines due to sustained positive economic conditions and record low unemployment levels. This growth in Medicaid underscores the significant impact of the federal COVID-19 PHE that required states to maintain continuous Medicaid coverage for an increase in federal Medicaid funding has had on Texas Medicaid enrollment.

Medicaid Managed Care Enrollment

In the beginning of state fiscal year 2023, HHSC contracted with 16 managed care organizations (MCOs) and 3 dental maintenance organizations (DMOs). Each MCO covers one or more of the service delivery areas (SDAs), while each dental plan provides statewide services (See ***Attachment A***). Approximately 97 percent of Texas Medicaid beneficiaries are enrolled in Medicaid managed care (MMC). The federal COVID-19 PHE continuous Medicaid coverage requirement has had the largest impact on the STAR program, which serves parent/caretakers, pregnant women, and children. The STAR+PLUS and STAR Kids programs have not experienced the same degree of impact. These programs include members with special health care needs (MSHCN) who are managed care clients either requiring regular, ongoing therapeutic intervention and evaluation, or with serious, ongoing illness, or a disability that may last for a significant period of time, resulting in longer lengths of stay in Medicaid.

Initiatives

During quarter four of federal fiscal year 2023, HHSC continued to operate the directed payment programs developed as part of the DSRIP Transition Plan.

[1] Demonstration Year 12 includes work that is tied to the state fiscal year as well.
[2] Enrollment data includes full-benefit Medicaid clients only. Data are final through February 2023. Data between March 2023 and September 2023 are preliminary with completion factors applied and are subject to change. September 2023 is projected. The monthly data reported to CMS for the required Medicaid and CHIP CAA Reporting Metrics do not encompass the same time period and will therefore differ.

Evaluation Activities

Evaluation activities during federal fiscal year 2023 for DY12 focused primarily on preparing for Texas A&M University's (TAMU) forthcoming Interim Evaluation Report #1 covering DYs 7-11, due on March 31, 2024, in accordance with the STCs. Specifically, HHSC received CMS approval for Revision 6.1 of the 1115 Evaluation Design covering DYs 7-11 and reviewed preliminary evaluation findings from TAMU. Additionally, HHSC began the process of extending TAMU's contract to cover the 1115 Evaluation Design for DYs 10-19.

COVID-19 Public Health Emergency

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

The Consolidated Appropriations Act of 2023 separated the continuous Medicaid coverage requirement of the Families First Coronavirus Response Act from the federal COVID-19 PHE declaration. HHSC started Medicaid redeterminations in April 2023 and continues to process redeterminations. HHSC must initiate all redeterminations by March 2024 and complete all redeterminations by May 2024 in alignment with Texas' federally approved End of Continuous Medicaid Coverage Mitigation Plan. HHSC reviewed all flexibilities implemented to address needs identified during the federal COVID-19 PHE to determine which flexibilities to end and which flexibilities to make permanent in compliance with federal requirements. To include completing the process to implement administrative rule changes allowing remote delivery of services when clinically appropriate. HHSC published final notices regarding the federal COVID-19 flexibilities in advance of the federal COVID-19 PHE ending on May 11, 2023.

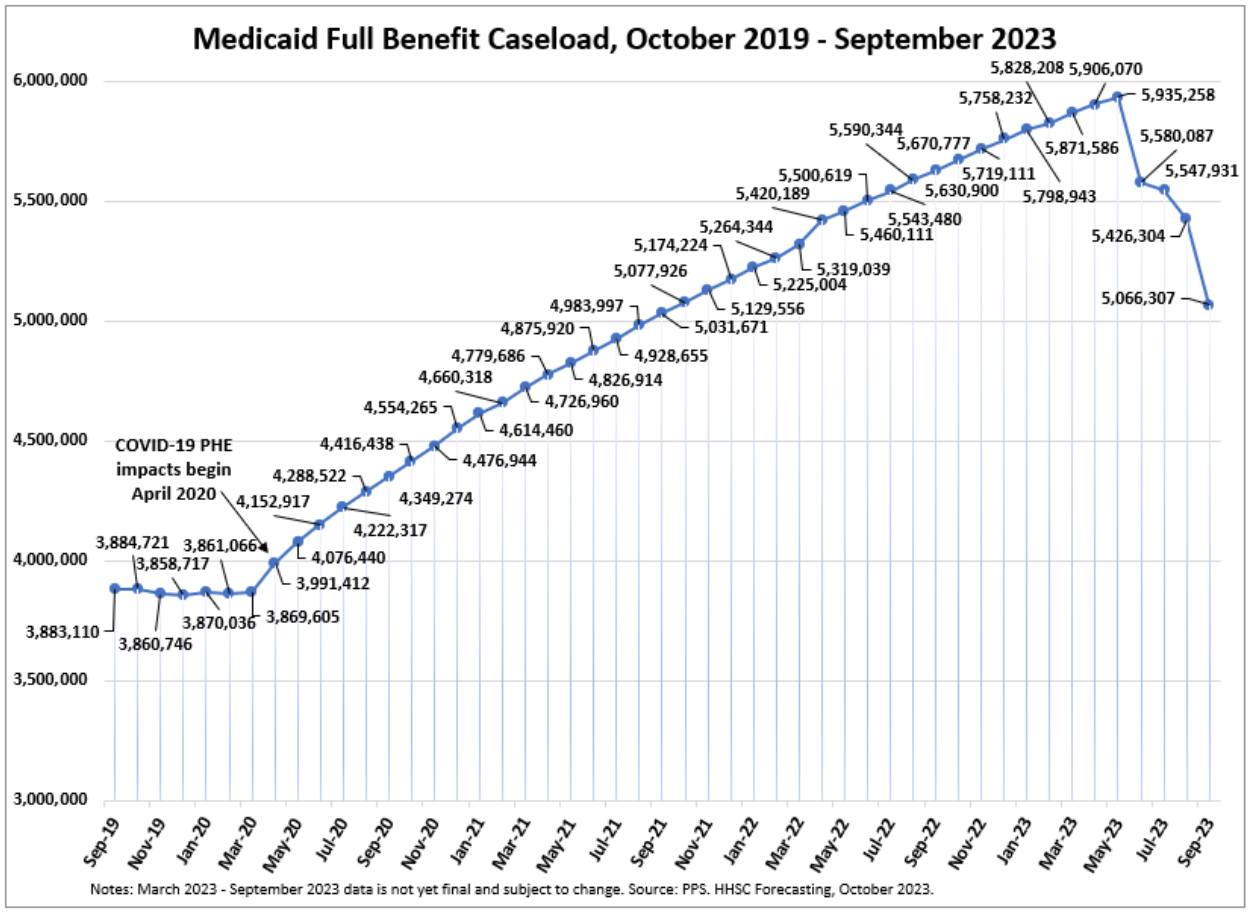
This report discusses in more detail the highlights included in this summary section. Due to data lags associated with primary sources of record, corresponding data submission timelines, and data cleaning procedures, each data attachment referred to and submitted to CMS reflects varying reporting periods. Certain numbers in this report have been rounded up or down and may not add up precisely to the totals provided, percentages may also not precisely reflect the absolute figures.

3. Enrollment

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

The graph below provides a visual look at the overall Medicaid caseload growth experienced during the federal COVID-19 PHE. Growth began in April 2020 and increased by over 2.0 million clients while disenrollment from Medicaid was suspended. Caseload growth began to decline in June 2023 once HHSC was federally required to resume Medicaid eligibility determinations which result in disenrollment for members determined ineligible. However, enrollment remains higher than the pre-PHE level by 1.2 million clients.

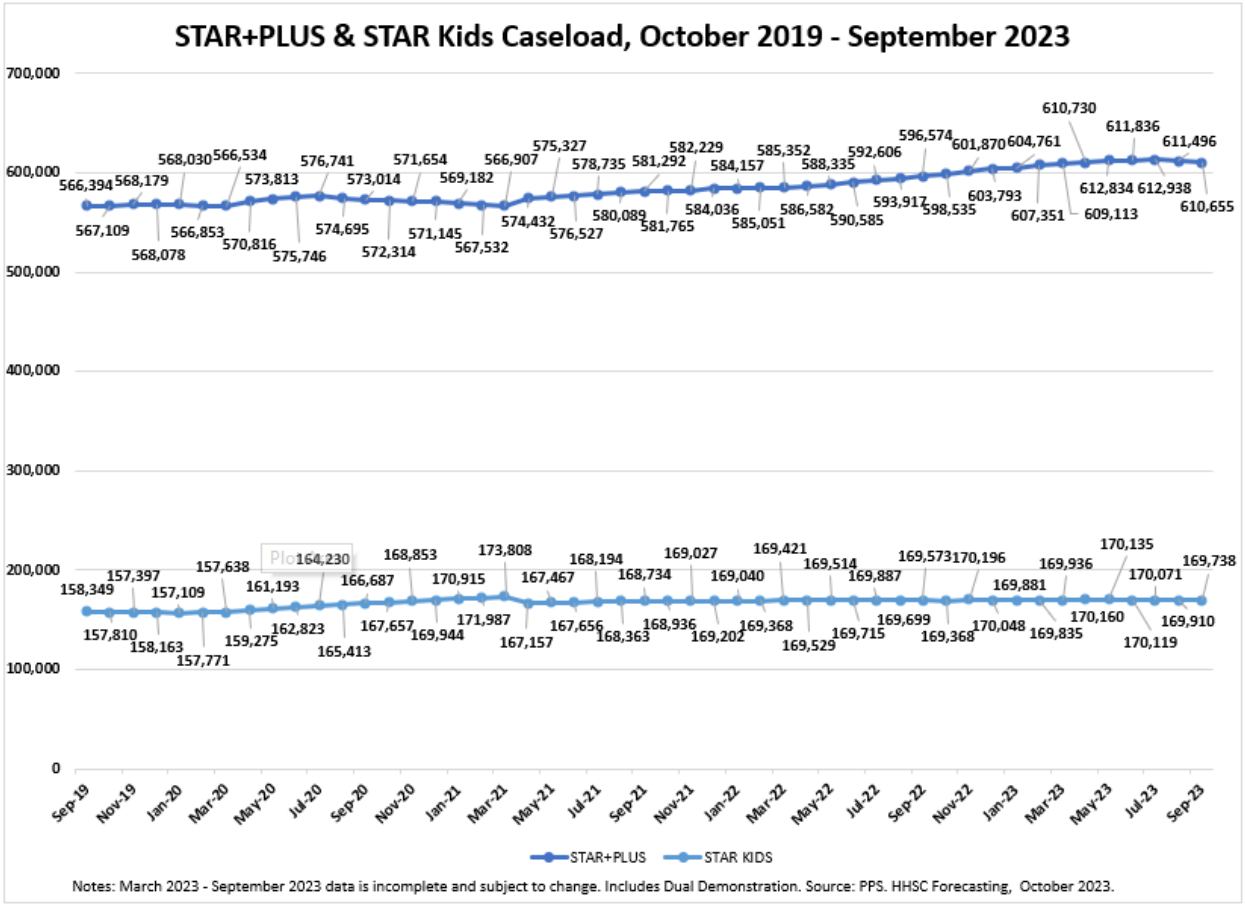
Figure 1. Medicaid Full Benefit Caseload, October 2019 - September 2023



Note: Data includes full-benefit Medicaid clients only. Data are final through February 2023. Data between March 2023 and September 2023 are preliminary with completion factors applied and are subject to change. The monthly data reported to CMS for the required Medicaid and CHIP CAA Reporting Metrics do not encompass the same time period and will therefore differ.

More than ninety-six percent of the growth in managed care during the federal COVID-19 PHE has been attributed to the STAR program, while disability-related managed care programs have experienced minimal impact. The graph below illustrates the impact to the STAR Kids and STAR+PLUS programs, which serve aged, blind, and disabled clients.

Figure 2. STAR+PLUS & STAR Kids Caseload, October 2019 – September 2023



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

In ***Attachment B1***, an enrollment summary is broken out by product line, service delivery area, and MCO for state fiscal year 2023 quarters one, two, and three to show where caseloads are headed. Due to the amount of time required for accurate data collection and reporting, total enrollment counts are reported on a one-quarter lag. ***Attachment B2*** includes Medicaid Enrollment Reports from December 2022 through February 2023. These reports include the estimated enrollment by delivery model, program, risk group, Medicaid MCOs and DMOs. The data are projections provided by HHSC Forecasting and are considered final after eight months.

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, as required in

the managed care contract. STAR MCOs must identify MSHCN based on criteria outlined in the managed care contract.

An MSHCN is defined as a member who:

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

HHSC established contractual requirements and a template for MCOs to submit monthly MSHCN data (See ***Attachment Q***). Beginning in August 2022, HHSC began collecting ***Attachment Q,*** or the *Service Coordination Report*, from MCOs, which includes more detailed data on service management and service coordination across all managed care programs, including contact attempts, reasons members declined service coordination, and the date the service plan was last updated. ***Attachment Q*** outlines STAR MSHCN, STAR Kids, and STAR+PLUS details by service delivery area (SDA) and MCO. Because of the time required for data collection, MSHCN data are reported on a one-quarter lag.

MCOs are required to provide service coordination to all STAR MSHCN, STAR Kids and STAR+PLUS members, unless the member declines or is unable to be reached. Service coordination also includes the development of a service plan to meet the members' short and long-term goals.

In state fiscal year 2023 quarter three, STAR MCOs reported an average of 179,118 children and adults identified as MSHCN. STAR Kids MCOs reported an average 169,915 children and STAR+PLUS MCOs reported an average 546,911 adults as MSHCN. On average, STAR MCOs reported 11 percent of MSHCN had a service plan, while STAR Kids and STAR+PLUS reported 42 percent and 39 percent of members had a service plan, respectively (See ***Attachment Q***). The number of members without service plans includes members who declined, could not be reached or located, died during the report period, moved out of the service area or state, those who had a service plan in development, and other reasons. Member counts are reported monthly; therefore, members may be counted more than once if a member moves out of a service delivery area, changes MCO or service coordination levels, or gains or loses a service plan within a quarter.

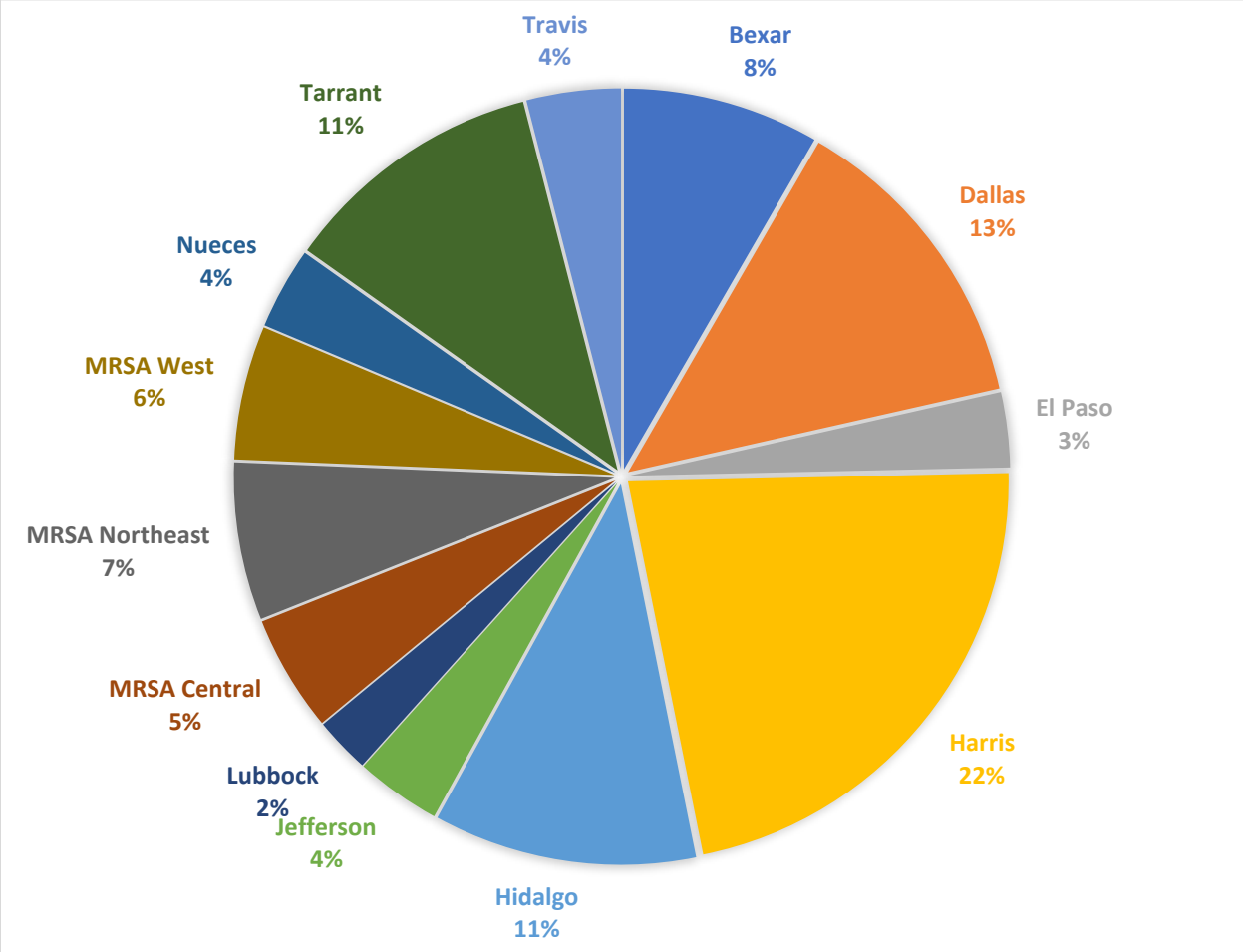
When comparing state fiscal year 2023 quarter two and quarter three, the overall percentage of MSHCN with service plans has remained consistent across all programs.

Table 2. MSHCN Members with a Service Plan by Program and Month 2023, Quarter 3

Program	Total MSHCN	Percentage of MSHCN with a Service Plan
STAR		
March 2023	181,498	10%

Program	Total MSHCN	Percentage of MSHCN with a Service Plan
April 2023	176,118	11%
May 2023	179,738	11%
STAR Kids		
March 2023	169,761	42%
April 2023	170,015	42%
May 2023	169,971	42%
STAR+PLUS		
March 2023	545,158	39%
April 2023	546,766	39%
May 2023	548,810	39%

Figure 3. Average STAR MSHCN, STAR Kids, and STAR+PLUS by SDA



HHSC reviews each submission of ***Attachment Q,*** the Service Coordination Report, to assess reporting errors and as needed, conducts targeted intervention with poor performing MCOs. HHSC also conducts biennial operational reviews of MCOs. These operational reviews are comprised of an in-depth review of MCO operational compliance and performance across several areas, such as service management and service planning, to ensure policies and practices align with performance standards, including managed care contract requirements. If any problems are discovered during the operational reviews, HHSC takes appropriate steps to address performance and compliance.

Anticipated Changes to Enrollment

On January 27, 2020, the Secretary of Health and Human Services declared a federal PHE due to the novel coronavirus (COVID-19). In March 2020, Governor Greg Abbott declared a disaster in Texas due to the COVID-19 pandemic. Additionally, the federal law passed in March 2020, H.R. 6201 (Families First Coronavirus Response Act), required States to maintain continuous Medicaid coverage during the federal COVID-19 PHE period as a condition of receiving enhanced federal funding. As part of the emergency response, HHSC put automated processes in place to maintain Medicaid coverage.

On October 28, 2020, CMS issued interim final rules which provided clarification on the continuous enrollment requirements in the Families First Coronavirus Response Act (FFCRA). CMS clarified states must transition individuals between eligibility categories during the federal COVID-19 PHE if the new Medicaid program provides the same tier of benefits or a higher tier of benefits. Texas has aligned with the interim final rule related to continuous Medicaid coverage requirements as part of the FFCRA.

Beginning in February 2021, HHSC transitioned Medicaid clients to the appropriate program on an ongoing basis when there was a change in circumstance or when processing a renewal application. Generally, if a client no longer meets the criteria for their current program and does not qualify for another Medicaid group in the same tier of benefits, the client will remain in their current group for the remainder of the continued eligibility period. There are limited situations where an individual will not continue to receive Medicaid State Plan benefits such as when the individual moves out of state, voluntarily withdrawals from the program, or dies.

On December 29, 2022, Congress passed the 2023 Consolidated Appropriations Act which separated the continuous coverage requirement from the public health emergency declaration.

- The continuous Medicaid coverage requirement ended as of March 31, 2023.
- Beginning April 1, 2023, states may disenroll members who are no longer eligible after receiving a Medicaid eligibility redetermination.

HHSC is redetermining the eligibility of all Texans receiving Medicaid, in alignment with Texas' federally approved End of Continuous Medicaid Coverage Mitigation Plan. HHSC divided the continuous Medicaid coverage population into three cohorts. The Medicaid continuous coverage population includes individuals who did not provide sufficient information to redetermine their coverage during the federal COVID-19 PHE, or who did not meet Medicaid eligibility requirements at their most recent renewal. Redeterminations for the cohort populations are being initiated in a staggered approach during the first six months of the state's unwinding period.

Individuals enrolled in Medicaid not included in the continuous coverage cohorts will have their eligibility redetermined based on their normal renewal dates during the unwinding period. These are members who have either completed a Medicaid renewal or submitted a new Medicaid application in the past 12 months and were determined eligible.

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

Additionally, to address the needs of providers and members participating in Medicaid, HHSC implemented policy and process flexibilities during the federal COVID-19 PHE related to services, provider enrollment, and assessments. HHSC reviewed flexibilities implemented to address needs identified during the PHE and determined which flexibilities to end and which flexibilities to make permanent in compliance with federal requirements. HHSC published final notices regarding the COVID-19 flexibilities that ended on May 11, 2023, when the federal COVID-19 PHE ended and the related provider and member notification requirements.

The Quarterly 1115 Waiver Texas Healthcare Transformation and Quality Improvement Program Monitoring Report and the monthly CMS Medicaid and CHIP CAA Reporting Metrics do not encompass the same time period and thus will not reflect the same data. In alignment with CMS requirements, the monthly Unwinding Data Report reports on outcomes for the total beneficiaries due for a renewal in the reporting period (the previous month). This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with an annual renewal due in the reporting period. The Quarterly 1115 Waiver Texas Healthcare Transformation and Quality Improvement Program Monitoring Report enrollment data includes a combination of final data, preliminary data for the past two quarters, and the most recent forecasting data for the month being reported, and only includes data for full beneficiaries.

Member Disenrollment

In alignment with CMS requirements, the monthly CMS Medicaid and CHIP CAA Reporting Metrics reports on outcomes for the total beneficiaries due for a renewal in the reporting period (the previous month). This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with an annual renewal due in the reporting period. Between April 1, 2023, and September 30, 2023, 1,246,722 Medicaid members have been disenrolled.[3]

[3] This number reflects disenrollments for any Medicaid renewals initiated between April 1, 2023, and September 30, 2023 as of October 6, 2023. While the data source is the same as the monthly CMS Medicaid and CHIP CAA Reporting Metrics, the number of reported disenrollments also includes pending renewals completed after the monthly reporting period.

4. Provider Network & Network Adequacy

To ensure the availability and accessibility of services in a timely manner, MCOs are required to meet network adequacy standards for time and distance. These vary by provider type and county designation (metro, micro, rural). MCOs must ensure at least 90 percent of members, unless otherwise specified, have access to a choice of each provider type (PCPs, dentist, and specialty services) in each SDA within prescribed travel time and distance standards. The required distance and travel time standards vary by provider and county designation (see ***Attachment E and Attachments H1-H4)***.

Attachment H1 provides an analysis of the percentage of each managed care plan's members with at least two PCPs within the maximum distance from the member's residence (based on Medicaid enrollment files) by program and county designation (metro, micro, rural) within the distance standard of 90 percent. During state fiscal year 2023 quarter four, all MCOs met or exceeded the 90 percent standard for members' access to PCPs. Similarly, MCOs are required to maintain an adequate network of specialty providers such that 90 percent of members have access to at least two providers (except as noted below) within the time and distance standard for the specialty provider type.

HHSC has established network adequacy standards for the following provider types and specialty: acute care hospital; audiologist; behavioral health outpatient; cardiovascular disease; ear, nose, and throat (ENT); Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR); general surgeon; nursing facility; OB/GYN; ophthalmologist; orthopedist; pediatric sub-specialty; prenatal care; SUD chemical dependency treatment; SUD opioid treatment; therapy (occupational, physical, and speech); psychiatrist; pharmacy; and urologist.

Attachment H2 presents the detailed specialty provider analysis by program and county designation (metro, micro, rural). During state fiscal year 2023 quarter four and across all Medicaid managed care programs, MCOs met or exceeded the 90 percent standard for members' access to specialty providers for Behavioral Health-Outpatient, Nursing Facility, OB/GYN, Pediatric Sub-specialty, Prenatal, and Therapy (occupational, physical, and speech). For the other specialty provider types, MCOs did not consistently meet network access standards during state fiscal year 2023 quarter four. The MCO's performance is being reviewed for further actions. The evaluation of network adequacy compliance occurs at the county, provider specialty, and MCO program level. It is possible for an MCO's overall average compliance rate to be high yet still be below 90 percent in one or more counties. The table below summarizes the count of MCOs that did not meet the 90 percent overall average compliance rate in one or more counties.

Figure 4. MCO Network Adequacy Summary – Specialty Providers – Number of MCOs that did not meet the standard, by Specialty Provider, Program and County designation for State Fiscal Year 2023 Q4

Type of Specialist	Program	Number of MCOs that did not meet the standard in a county

		Metro County	Micro County	Rural County
Acute Care Hospital	STAR	3	7	14
	STAR+PLUS	1	4	4
	STAR Kids	1	5	6
Audiologist	STAR	8	8	7
	STAR+PLUS	2	4	4
	STAR Kids	3	3	5
Behavioral Health – Outpatient	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Cardiovascular Disease	STAR	1	3	0
	STAR+PLUS	0	0	0
	STAR Kids	1	0	0
ENT (Otolaryngology)	STAR	0	2	1
	STAR+PLUS	0	1	1
	STAR Kids	0	0	2
General Surgeon	STAR	0	2	0
	STAR+PLUS	0	1	0
	STAR Kids	0	1	0
Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR)	STAR	11	14	8
	STAR+PLUS	4	4	4
	STAR Kids	6	9	5
Nursing Facility	STAR+PLUS	0	0	0
OB/GYN	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Ophthalmologist	STAR	2	3	1
	STAR+PLUS	0	1	1
	STAR Kids	2	3	1
Orthopedist	STAR	0	4	0
	STAR+PLUS	0	2	0
	STAR Kids	0	4	1
Pediatric Sub-Specialty	STAR	0	0	0
(*The standard requires access to one provider*)	STAR Kids	0	0	0
Pharmacy	STAR	14	12	2
	STAR+PLUS	3	4	1

	STAR Kids	5	7	0
Prenatal	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Psychiatrist	STAR	1	4	2
	STAR+PLUS	0	2	1
	STAR Kids	1	2	1
SUD Chemical Dependency Treatment	STAR	4	10	2
	STAR+PLUS	2	4	3
	STAR Kids	3	8	4
SUD Opioid Treatment	STAR	14	14	13
	STAR+PLUS	4	4	4
	STAR Kids	8	9	6
Therapy (Occupational, Physical, and Speech)	STAR	0	0	0
	STAR+PLUS	0	0	0
	STAR Kids	0	0	0
Urologist	STAR	1	3	4
	STAR+PLUS	0	2	2
	STAR Kids	1	2	4

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

Attachment H3 provides dentist analysis by DMO and county designation. During state fiscal year 2023 quarter four, all DMOs met the network access standard of 95 percent for Main Dentist in all county types.

Attachment H4 provides dental specialty analysis by provider type and county designation. The DMOs did not consistently meet network access standards of 90 percent for dental specialty provider types during state fiscal year 2023 quarter four. The DMOs' performance is being reviewed for further actions.

Figure 5. DMO Network Adequacy Summary

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

	United HealthCare Dental	0	1	1
Oral Surgeon	DentaQuest	0	1	1
	MCNA Dental	0	0	0
	United HealthCare Dental	0	0	1
Orthodontist	DentaQuest	0	1	1
	MCNA Dental	0	1	1
	United HealthCare Dental	0	1	1
Pediatric Dentist	DentaQuest	0	0	0
	MCNA Dental	0	0	0
	United HealthCare Dental	0	1	0

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

In addition to monitoring network adequacy performance of the MCOs related to primary and specialty care, HHSC continues to enhance efforts to monitor long-term services and supports, in particular, community attendant care. As part of the implementation of the Community Attendant Workforce Development Strategic Plan required by the 2020-21 General Appropriations Act, House Bill 1, 86th Texas Legislature, Regular Session, 2019 (Article II, HHSC, Rider 157)[4], HHSC is enhancing provider network adequacy standards for Medicaid MCOs to ensure members have sufficient access to community care attendants. Managed care contracts have been updated to clarify that MCOs must ensure that a minimum of 90 percent of their members have timely access to community attendant care services upon authorization of services. Timeliness is defined as within seven days from the authorization. Initial data will provide a baseline for future performance monitoring, with the expectation that MCO performance will improve over time. HHSC continues to refine and improve the collection and analysis of this data. As the data and analysis processes continue to mature and more baseline data is compiled, HHSC expects the data quality to become more refined. HHSC is conducting a data validity analysis.

MCO Pharmacy Geo-mapping Summary

In November 2023, HHSC began reviewing the current and proposed methodology to determine if changes to the pharmacy distance and travel time standards are appropriate. The review is underway and more information on the results of the analysis will be available in the next annual report. . Pharmacy network adequacy performance reports were shared with MCOs as informational only.

Attachment J details the Geo-distance results for state fiscal years 2022 and 2023 to inform the process and information as HHSC continues to work on network adequacy as it relates to pharmacy. MCOs are required to provide pharmacy access to members in each SDA within the contractual performance standards. Effective state fiscal year 2019, the performance standards changed as follows:

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

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

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

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

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

Managed Care Provider Network

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

During state fiscal year 2023 quarter three, the unique number of credentialed specialist providers increased in all programs. Additionally, the number of unique credentialed pharmacy providers increased in all programs statewide during state fiscal year 2023 quarter three. Across the dental program statewide, the DMOs reported an increase in credentialed specialist providers compared to the previous quarter.

Provider Termination

Attachment C3 details the data reported by the MCOs regarding the number of PCPs and specialists terminated in state fiscal year 2023 quarter three. The MCOs reported a variety of reasons for termination. For state fiscal year 2023 quarter three, the top three reasons for PCP and specialist terminations included: the provider moved, the provider left group practice and termination was requested by the provider. Because of the time required for data collection, provider termination counts per quarter are reported on a one-quarter lag.

MCO and DMO Network Adequacy Standard Exceptions

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

they are ensuring access to care using teleservices. A formal CAP will be requested if the MCO's plan is insufficient. The MCO must ensure continuity of care.

As a part of HHSC's process, MCOs and DMOs may submit an exception request for areas of non-compliance using the network adequacy corrective action process. HHSC approves or denies the exception request based on the review of supporting information that demonstrates an MCO's provider contracting efforts and assurances of access to care. As part of the exception, the MCO must implement strategies to proactively contact and provide education to the impacted members on how to access care by approaches such as providing a list of network providers in the area, providing guidance and a list of network providers offering telehealth and telemedicine services, how to access care outside of the area, how to contact member services and the member hotline, what to do in case of an emergency, and how to access non-emergent medical transportation and the MCOs' transportation value-added service, if available. The MCO must ensure continuity of care.

If an exception request is denied, the MCO is subject to remedies such as a CAP or liquidated damages.

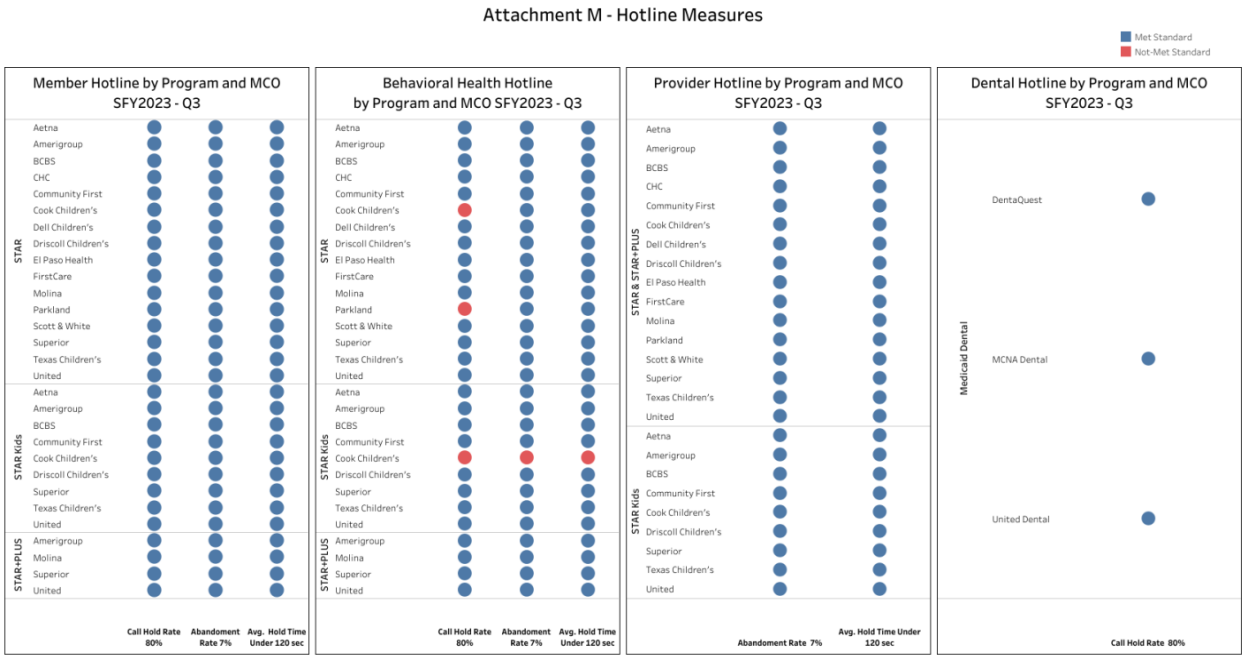
Hotline Performance

The MCOs and DMOs must have toll-free member and behavioral health hotlines (behavioral health hotline not applicable to DMOs), that members can call 24 hours a day, 7 days a week. The MCOs and DMOs must also have a toll-free provider hotline that is available for provider inquiries from 8:00 a.m.–5:00 p.m. local time for the Service Area, Monday through Friday, except for State-approved holidays. The performance standards for these member and provider hotlines are listed below:

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

Included in ***Attachment M1-M4*** is data from state fiscal year 2023 quarter three. Because of the time required for data collection, Member Hotline data are reported on a one-quarter lag. A summary of findings using aggregated MCO self-reported data is reported below.

Figure 6. Hotline Performance SFY23 Quarter 3



The above instances of non-compliance are being addressed by HHSC. MCOs that have identified instances of non-compliance are reviewed quarterly for remedies as stated in the contract that include but are not limited to CAPs and liquidated damages assessments.

Provider Open Panel

MCOs submit provider files identifying the number of PCPs and main dentists who are accepting new Medicaid patients, which are described here as "open panel" PCPs and "open practice" dentists. HHSC monitors PCPs with "open panel" at an 80 percent benchmark.

Quarterly healthcare provider counts are reported on a one-quarter lag. In state fiscal year 2023 quarter three, all MCOs and DMOs met the 80 percent benchmark, except Cook Children's (72 percent) in STAR and Cook Children's (69 percent) in STAR Kids. HHSC is monitoring on an ongoing basis and has not identified access to care concerns, issues, or complaints with this MCO.

Appointment Availability

HHSC directly monitors MCO provider networks. Section 8.1.3 of the Uniform Managed Care Contract, and corresponding sections of the other managed care contracts, requires that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters. MCOs that do not meet minimum performance thresholds are subject to contract remedies, including CAPs and liquidated damages (LDs). For quarter four of state fiscal year 2023, the primary care provider and behavioral health studies were conducted. The standard and results for each study are outlined in the following tables.

Table 3. Primary Care Provider (PCP) Appointment Wait Standards

Type of Care	Standard
Preventive health services for new child members	Within ninety (90) calendar days of enrollment
Preventive health services for adults	Within ninety (90) calendar days
Routine primary care (child and adult)	Within fourteen (14) calendar days
Urgent care (child and adult)	Within twenty-four (24) hours

Table 4. 2023 Percentage of Providers in Each MCO that Met the UMCC PCP Appointment Availability Standards

Program	Standard	2023 Program Compliance
STAR Adult	Preventive	99.6%
	Routine	100%
	Urgent	100%
STAR Child	Preventive	99.6%
	Routine	100%
	Urgent	100%
STAR +PLUS	Preventive	99.1%
	Routine	100%
	Urgent	100%
STAR Kids	Preventive	99.1%
	Routine	100%
	Urgent	100%

Table 5. 2023 Behavioral Health Care Appointment Wait Standards

Type of Care	Standard
Initial Outpatient BH Appointment	Within fourteen (14) calendar days

Table 6. 2023 Percentage of Providers in Each MCO that Met the UMCC BH Appointment Availability Standards

Program	2023
STAR Adult	84.3%

Program	2023
STAR Child	84.5%
STAR+PLUS	95.2%
STAR Kids	86.4%

Accessibility and Language Compliance

MCOs submit provider language and accessibility survey results by program and SDA on an annual basis. Deliverables for state fiscal year 2022 are due from MCOs on December 15, 2023, and will be summarized in the state fiscal year 2024 quarter one report.

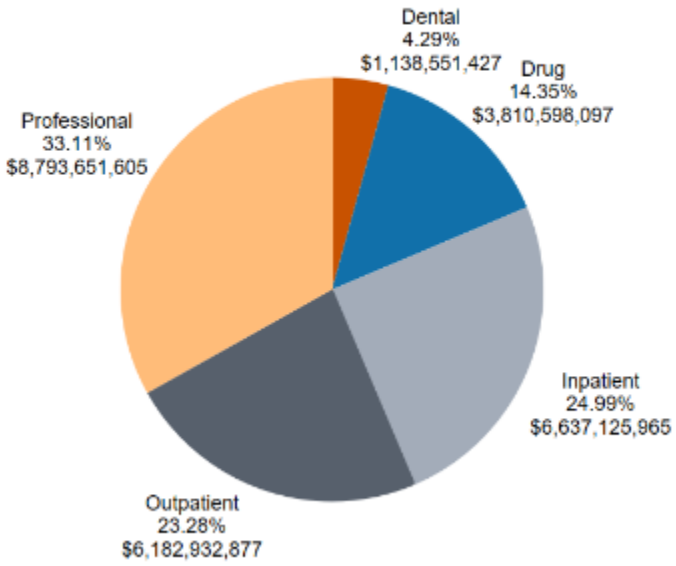
HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, 7 days a week, and outlines specific criteria for what constitute compliance with the managed care contracts. For example, providers must offer after-hours telephone availability through an answering service, recorded messages with contact information for on-call PCP, or call forwarding routing the caller to the on-call PCP or an alternate provider.

Each MCO is also required to systematically and regularly verify that covered services furnished by PCPs meet the 24/7 access criteria and enforce access standards in non-compliance. MCOs survey providers on a quarterly, semiannual, or annual basis to assess compliance for 24/7 and after-hours provider accessibility. MCOs utilize methods including computer-assisted telephone interviews, telephone surveys (non-computerized), mailed surveys, monthly secret shopper calls and face-to-face provider visits to measure provider accessibility compliance with the HHSC contractual standards. Provider compliance rates for 24/7 accessibility ranged from 30 percent to 100 percent. Providers who are not in compliance with 24/7 accessibility standards receive phone calls or letters from the MCOs detailing the requirements and are subject to remediation methods including mailed provider re-education letters regarding the managed care contractual standards, follow-up surveys, face-to-face re-education (e.g., evaluating and coaching provider staff, training) and unscheduled calls to providers to reassess compliance. MCOs employ contractual remedies for the provider until compliance is achieved or the provider contract is terminated.

Service Utilization

Attachment S illustrates enrollment and expenditures by program and claim type for state fiscal year 2022, covering September 1, 2022, through August 31, 2023. In each annual report, HHSC reports the prior fiscal years data in order to include more complete data. These visualizations represent Medicaid encounter utilization data and Medicaid client enrollment data reported by program, MCO, SDA, and claim type. These data are self-reported by the MCOs and are subject to change. The total spending in STAR, STAR+PLUS, and STAR Kids in state fiscal year 2022 are shown in the figure below.

Figure 7. 2022 Expenditures by Claim Type



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

Out-of-Network (OON) Utilization

MCOs are required to submit the OON Utilization Report for each SDA in which the MCO operates. In each SDA, the OON utilization should not exceed the following standards.

- 15 percent of inpatient hospital admissions.
- 20 percent of emergency room (ER) visits.
- 20 percent of total dollars billed for other outpatient services.

HHSC continues to work closely with MCOs to ensure compliance with the OON utilization standards. MCOs may submit a Special Exception Request Template (SERT) for areas of non-compliance. HHSC approves or denies the SERT based on the review of supporting information that demonstrates why the MCO was unsuccessful in provider contracting efforts. If approved, the MCO submits a recalculated OON Utilization Report, excluding the utilization of the aforementioned provider(s). If the recalculation does not bring the MCO into compliance, the MCO remains non-compliant and is subject to contract action such as assessing liquidated damages or implementing a CAP.

Attachment D provides OON utilization performance summary for state fiscal year 2023 quarter three. Because of the time required for data collection, OON utilization counts are reported on a one-quarter lag.

The MCOs listed below exceeded OON utilization standards and have a SERT in place. HHSC will continue to monitor OON utilization and will require corrective action or other remedies as appropriate.

OON Emergency Room (ER) (<20 percent Standard)

- STAR
  - CHC (29.25 percent) – Approved SERT on file
  - Dell (48.74 percent) – Approved SERT on file

OON Inpatient (<15 percent Standard)

- STAR
  - Dell Children's (25.55 percent) – Approved SERT on file

Oversight of MCOs and DMOs

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

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

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

5. Waiver Amendments and Upcoming Initiatives

Waiver Amendments

The following amendments have been submitted to CMS or are in development.

Medically Fragile

House Bill 4533, 86th Texas Legislature, Regular Session, 2019 (Section 32), requires HHSC to pursue a benefit for medically fragile individuals. If determined to be cost effective, the legislation directed HHSC to submit an amendment to add this benefit to the 1115 Transformation waiver under the STAR+PLUS Home and Community Based Services (HCBS) program. HHSC submitted this amendment to CMS on September 1, 2020. After the original submission, CMS indicated the packet was not complete, and HHSC was required to resubmit the packet to CMS. The second submission of the packet was on February 22, 2021. On October 20, 2023, CMS sent HHSC the draft STCs and authorities to review for this amendment. HHSC re-submitted the STCs on October 27, 2023, as requested by CMS. On November 16, 2023, CMS sent HHSC the approved STCs.

Preferred Drug List (PDL) Prior Authorizations (PA)

On September 6, 2023, HHSC sent a written request to CMS to withdraw the Preferred Drug List (PDL) Prior Authorizations (PA) amendment. CMS accepted HHSC's request to withdraw the amendment and the administrative record was updated on September 9, 2023, to reflect the withdrawal.

Maternal and Child Health

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

- Transition targeted Case Management for Children and Pregnant Women (CPW) services to Medicaid managed care. HHSC submitted this amendment on May 4, 2022, with a requested effective date of September 1, 2022. On October 20, 2023, CMS sent HHSC the draft STCs and authorities to review for this amendment. HHSC re-submitted the STCs on October 27, 2023, as requested by CMS. On November 16, 2023, CMS sent HHSC the approved STCs.
- Extend postpartum Medicaid coverage from 60 days to six months following delivery or involuntary miscarriage. HHSC submitted this amendment on May 25, 2022, with a requested effective date of September 22, 2022. HHSC and CMS continue to discuss the amendment.
- Transition the Healthy Texas Women (HTW) program services[5] into managed care. An amendment has not yet been submitted to CMS. HHSC plans to implement HTW managed care in quarter one of state fiscal year 2026 in alignment with the STAR and CHIP Request for Proposal.

2nd Reassessment of the UC Pool Program

HHSC proposes amending STC 41(d) Reassessment of Hospital's Uncompensated Charity Care in 2027, to make clear what years and data sources will be used for the reassessment to ensure that the public health emergency does not impact the data utilized. Through this amendment, HHSC clarifies in STC

[5] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83311

41(d) that Medicaid payment data from 2025 as determined by the claim and encounter data maintained by Texas will be used to avoid any impacts from the data caused by the COVID-19 public health emergency. The proposed effective date for this amendment is December 31, 2023. HHSC submitted this amendment to CMS on May 1, 2023. CMS subsequently approved the proposed change via a letter dated October 18, 2023.

Upcoming Initiatives

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

Texas continues efforts to comply with the federal HCBS settings regulations issued by CMS in March 2014. Compliance efforts include revising state rules and policies and conducting heightened scrutiny assessments on all STAR+PLUS HCBS assisted living facility settings. HHSC revised managed care contracts to require MCOs to ensure their contracted providers comply with the HCBS settings regulations. These contract amendments became effective in September 2022. HHSC received initial approval of the Statewide Transition Plan on December 21, 2022, and resubmitted a revised STP to CMS for final approval in March 2023, following a required public comment period. HHSC received final CMS approval of the STP in July 2023.

HHSC received CMS's "site visit report" in April 2023 summarizing CMS findings from CMS's recent site visit to Texas to assess several STAR+PLUS HCBS assisted living facility settings. HHSC worked with CMS to develop a corrective action plan (CAP) to address outstanding compliance actions identified in the report. The CAP was approved by CMS in October 2023 and outlines remediation activities to be completed by September 1, 2025.

Community Attendant Workforce Development Strategic Plan

The Community Attendant Workforce Development Strategic Plan was submitted to the legislature and Governor's office pursuant to legislative direction in 2019. The plan contains strategies related to recruiting and retaining community attendants and ensuring Medicaid recipients have adequate access to services. More specifically, the plan includes information and data about the community attendant workforce in Texas; feedback collected from stakeholders during a cross-agency forum and an online survey; and HHSC's long-term goals and recommendations for addressing challenges faced by individuals receiving community attendant care, as well as providers.

HHSC is currently working to implement the strategies identified in the strategic plan and explore stakeholder recommendations. Some of these strategies that relate directly to the waiver include dedicating resources at HHSC to coordinate and support a Workforce Development Taskforce.

- HHSC identified the Office of Disability Services Coordination as the dedicated resource to launch, support, and manage a taskforce. The Direct Service Workforce Development Taskforce (DSW Taskforce), launched in March 2021, is a collaborative workgroup whose purpose is to explore long-term recruitment and retention (non-wage based) strategies, which were proposed by stakeholders, within the community attendant, personal care attendant, and direct service workforce. The DSW Taskforce provided input into the THTQIP 1115 Waiver application, HHSC's spending plan in response to the ARPA (American Rescue Plan Act) Section 9817 which provides States with a temporary ten percent point increase to the federal medical assistance percentage for Medicaid HCBS, and the project plan to explore recruitment and

retention (non-wage based) strategies. The project plan has two main goals—enhance workforce development and improve data collection—and 28 individual projects within a three state-fiscal-year project period. Ten of the projects are already complete, ten are in progress, and eight have yet to be started.

- During federal fiscal year 2023 quarter four, HHSC launched Direct Care Careers (DCC), an optional, online portal that connects potential employees with employers delivering home and community-based services through the state plan and HCBS authorities (1915(c), 1915(i), 1915(j), and 1115). HHSC is planning for additional features and improvements in the future, including enhanced Search functionality, as well as providing links to trainings and additional resources for employers and employees. HHSC also launched an in-depth advertising campaign for DCC that included emails sent via GovDelivery, Facebook, Instagram, LinkedIn and Twitter posts, as well as flyers and business cards.

Critical Incident Management System

HHSC has implemented a new statewide critical incident management system (CIMS) for reporting critical incidents. The new system complies with guidance issued by CMS on March 12, 2014. The 2020-2021 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019, appropriated funding to streamline the level of critical incident information received and to standardize the format for the new CIMS. HHSC has worked diligently with FEI Systems, the CIMS vendor, to configure a platform to collect all required critical incident information across all 1915(c) and the 1115 STAR+PLUS HCBS programs. It includes information on abuse, neglect, and exploitation (ANE) allegations in addition to other non-ANE critical incidents, including deaths, and data collection at the individual level to inform ongoing quality improvement. CIMS went live for fee-for-service waiver providers in July 2022. HHSC gave those providers a grace period to November 1, 2022, to fully utilize the system. The implementation process required provider training by program, system testing, coordination between reporting systems, and assessments of program reporting requirements.

HHSC continues to closely monitor all ongoing activities involved with CIMS implementation.

6. Demonstration-related Appeals and Complaints

Complaints Received by the State and MCOs

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

Attachment O[6] includes complaints data compiled from both MCOs/DMOs and HHSC for members and providers. The reports in ***Attachment O*** reflect state fiscal year 2023 quarter two. Subsequent monitoring reports will continue to be reported on a two-quarter lag. Complaint data are displayed by the following:

- Top five most frequent types of complaints overall, separately for members and providers, by program, and by MCO/DMO.
- Outcome status by program and by MCO/DMO.
- Distribution of complaints and enrollment by MCO/DMO.
- Overall quarterly rate of complaints by MCO/DMO, including previous six quarters (as the data becomes available).

Generally, the total number of complaints submitted is small relative to the total number of individuals enrolled in Medicaid per month. Complaint data are represented as the number of complaints per 10,000 clients (otherwise referred to as rate). Complaint volumes may vary based on MCO/DMO size, program (e.g., STAR versus STAR+PLUS), and complexity of population served.

Member Appeals

Attachment N is reported on a one-quarter lag and provides a performance summary of member appeals for state fiscal year 2023 quarter three. During the reporting period, STAR MCOs collectively reported 3,534 member appeals resolved. STAR+PLUS MCOs reported 2,556 and STAR Kids MCOs reported 1,154 member appeals resolved. DMOs collectively reported 515 member appeals resolved.

Member appeal reports are submitted monthly. Most MCOs met the compliance standard for one or more months. Dell Children's Health Plan did not meet the 98 percent compliance standard for 30-day appeals resolved timely in the STAR program. Amerigroup did not meet the 98 percent compliance standard for 30-day appeals resolved timely in the STAR, STAR Kids, or STAR+PLUS programs. Texas Children's Health plan did meet the 98 percent standard for expedited appeals resolved in one day for the STAR program. Identified instances of non-compliance are reviewed quarterly for remedies, as stated in the contract, that include but are not limited to CAPs and liquidated damages assessments.

Provider Fraud and Abuse

MCOs and DMOs are required to send referrals regarding Medicaid waste, abuse, or fraud to the HHSC Office of Inspector General (OIG). Please see ***Attachments R1 and R2*** for MCO and DMO provider

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

referral details during state fiscal year 2023 quarters one through four. These attachments include the total number of referrals received and the allegation category.

Claims Summary Reports

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

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

Claims summary counts are reported on a one-quarter lag and reflect data through state fiscal year 2023 quarters one through three. ***Attachment V1*** provides a claims summary for the STAR program. ***Attachment V2*** provides claims summary for the STAR+PLUS program. ***Attachment V3*** provides a claims summary for the Dental program. ***Attachment V4*** provides a claims summary for the STAR Kids program.

Fair Hearings

The Fair and Fraud Hearings Department (FFH) of the Appeals Division of the HHSC receives appeal requests from applicants and clients contesting actions taken regarding benefits and services for various programs. Fair Hearings Officers conduct fair hearings and administrative disqualification hearings statewide for 171 eligibility programs within HHSC, including the waiver programs.

In the fourth quarter of state fiscal year 2023, FFH received 557 fair hearing requests for the programs authorized under the waiver (69 for the STAR program, 117 for the STAR Kids program, and 371 for the STAR+PLUS program). FFH has issued 524 decisions related to the waiver in the fourth quarter, 121 were withdrawn by the appellant, 201 were dismissed, 169 were upheld, and 33 were reversed by the presiding Fair Hearings Officer. Of the 557 fair hearing requests received in the quarter, 33 decisions were pending final resolution. The data for the appeal requests were from Appeals sent July 1, 2023 through September 30, 2023. The data for the decisions are from Decisions issued from July 1, 2023, through September 30, 2023. Although an appeal request has been sent, the appeal may not be heard and decided prior to the end of the quarter, hence the difference in the data.

External Medical Review

HHSC implemented an External Medical Review (EMR) option, to be performed by an Independent Review Organization (IRO) in May 2022. The EMR is an option for a member to request further review of the MCO's adverse benefit determination. The EMR takes place between the MCO internal appeal process and the State Fair Hearings. The MCO has to provide the IRO the same set of records the MCO reviewed to determine service denial or reduction. EMRs are conducted by IROs contracted with HHSC. The role of the IRO is to act as an objective arbiter and decide whether the MCO's original adverse benefit determination must be reversed or affirmed.

In the fourth quarter of state fiscal year 2023, HHSC received 126 EMR requests for the following Medicaid managed care programs: 26 for the STAR program, 32 for the STAR Kids program, and 68 for the STAR+PLUS program. Of the 126 EMR requests, 96 MCO internal appeal decisions were upheld by the IRO, 28 MCO internal appeal decisions were overturned by the IRO, and two MCO internal appeal decisions were partially overturned by the IRO. There was an overall decrease of 57 requests (31 percent) from the previous quarter. However, this is a 61 percent increase from fourth quarter state fiscal year 2022 under the same program submissions where 78 EMRs were received. Due to the small numbers across all plans, no trends or issues were identified.

7. Quality

Quality of Care

As part of each MCO's quality performance in Texas Medicaid, HHSC calculates annual and monthly quality measures and posts results on the Texas Healthcare Learning Collaborative (THLC) Portal. The Portal is located at thlcportal.com. These quality measures are referred to as Quality of Care (QOC) measures. QOC measures are not mandated by state or federal statute or rule, but instead are the basis of many state initiatives and the state's managed care quality strategy.

HHSC received MCO quality measure results in August 2023 for measurement year 2022. Complete and final 2022 results will be posted on the THLC portal (thlcportal.com). The results will help inform HHSC decisions about quality improvement programs for measurement years 2023 and 2024.

HHSC meets monthly as part of Managed Care Oversight to review MCO statewide performance. In collaboration with Value-Based Initiatives, Quality Assurance (QA) provides MCO quality snapshots to summarize MCO performance on quality improvement initiatives. MCO quality snapshots provide high-level details on Appointment Availability, MCO Report Cards, Performance Indicator Dashboard results, Medical Pay-for-Quality, and Value-Based enrollment. Through these reviews, HHSC promotes opportunities for intra-agency collaboration and innovation in quality improvement efforts.

Performance Improvement Projects (PIPs)

HHSC works with the EQRO to review MCO and DMO performance on quality measures and identify areas needing improvement. MCOs and DMOs are required to begin a two-year PIP for each program (CHIP, STAR, STAR+PLUS, etc.) in January of every calendar year. As a result, plans have at least two PIPs in progress in any given year, and some plans may have many PIPs running concurrently.

HHSC received the 2022 and 2023 PIP Progress Reports evaluations from the EQRO for MCOs to review and incorporate feedback. The topic in 2022 for MCOs is to improve maternal health by focusing on social determinants of health (SDOH) and reducing health disparities, while for DMOs the topic is to improve the Receipt of Sealants on First Permanent Molar measure. The topic in 2023 for MCOs is to reduce potentially preventable admissions (PPA) for behavioral-health (BH) related diagnoses, and for DMOs the topic is to increase the DQA oral evaluation measure.

Non-emergency Medical Transportation (NEMT)

HHSC contracted with the Institute for Child Health Policy at the University of Florida, the Texas external quality review organization (EQRO), to conduct two surveys on Non-emergency Medical Transportation (NEMT). The first, the Medicaid NEMT Experience survey described the experience of Medicaid managed care members, medical providers, and Medicaid NEMT Providers that provided services to Medicaid managed care members after the June transition of transportation services into Medicaid Managed Care (MMC). The second, as directed by Rider 12(a) of the Texas General Appropriations Act (Article II, HHSC 86th Legislature, Regular Session, 2019), , was a one-time Medicaid NEMT Unmet Needs Survey focusing on Medicaid managed care members who were eligible for NEMT services but did not utilize them.

The NEMT Services Experience survey found:

- 5.4 percent of surveyed caregivers and 10.7 percent of adults in MMC indicated they usually or always missed a medical or dental appointment because of a lack of transportation.
- Among adults and caregivers of children in MMC, 83.6 and 84 percent, respectively, said they were satisfied or very satisfied overall with any form of mass transit they received from Medicaid NEMT providers.
- 66.4 percent of surveyed medical providers said they think arriving late to medical appointments impacts the overall preventative care that MMC members receive.
- 55.9 percent of surveyed medical providers said they think arriving late impacts the overall quality of care that members receive.

The Unmet Needs Survey found:

- 12.1 percent of MMC members who did not use transportation services indicated it was ‘difficult’ or ‘very difficult’ to find transportation to the doctor or dentist. This percentage is below the 16 percent reporting threshold established by the Texas legislature in 2019.
- Difficulty getting transportation that meets scheduling needs was the most frequently noted barrier to medical transportation cited by caregivers for children in MMC and adult MMC members.

8. HCBS Quality Assurance Reporting

As required by STC 75, HHSC submitted the second STAR+PLUS HCBS performance measure report on March 28, 2023. HHSC has continued to research current MCO deliverables and other Medicaid data sources in order to develop performance measures which will fully support the 1915(c) assurance requirements for the STAR+PLUS HCBS waiver program on a long-term basis. The STAR+PLUS HCBS population is included in the National Core Indicators - Aging and Disabilities 2023-2024 survey cycle. The final report is expected to be received in early 2026, and survey results will support the HCBS Quality Measure Set requirements. Other HHSC initiatives include developing MLTSS quality measures at the STAR+PLUS HCBS level to further align future reports with the HCBS Quality Measure Set.

HHSC is finalizing data collection and reporting processes for the third iteration of the report with a submission date of March 29, 2024.

9. Directed Payment Programs

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

State Fiscal Year 2023

On August 1, 2022, CMS approved five directed payment programs:

1. Directed Payment Program for Behavioral Health Services (DPP for BHS),
2. Quality Incentive Payment Program (QIPP),
3. Comprehensive Hospital Increase Reimbursement Program (CHIRP),
4. Texas Incentives for Physicians and Professional Services (TIPPS), and
5. Rural Access to Primary and Preventive Services Program (RAPPS).

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

Attachments K1-K11 include State Directed Payment data in the form of the required chart for CHIRP, DPP BHS, QIPP, RAPPS, TIPPS, reporting results, and the minimum fee schedules in state fiscal year 2023. Participating providers in CHIRP, DPP BHS, RAPPS, and TIPPS completed their year two provider reporting in quarter four.

State Fiscal Year 2024

The State submitted the fiscal year 2024 preprints for the aforementioned five state directed payment programs on March 15, 2023. The State submitted responses to the second round of questions from CMS on July 11, 2023, and CMS approved all five programs on July 31, 2023.

10. Financial/Budget Neutrality

This section addresses the quarterly reporting requirements regarding financial and budget neutrality development and issues. The budget neutrality workbook is on a one-quarter lag (see ***Attachment P***) and provides actual data through federal fiscal year 2023, quarter three and forecasted data for quarter four.

HHSC developed federal fiscal year 2023 Medicaid managed care rates that meet the actuarial soundness and federal requirements. Actuarial certification reports were submitted to CMS and the Office of the Actuary 45 days prior to the start of the rating period. HHSC is still awaiting approval of many of the contracts and capitation rates for federal fiscal year 2023.

Due to the significant impact of the COVID-19 PHE, HHSC adjusted the standard base periods used in prior rate settings. Beginning March 2020, all programs experienced significant declines in the average cost due to large scale shutdowns and deferral of services. As a result, we determined that the March 2020 through August 2020 data is not indicative of future cost patterns. The base period for all rating components was defined as March 2019 through February 2020 which is the most recent twelve-month period not impacted by the PHE. In the actuaries' opinion, COVID-19 presented unprecedented challenges to setting prospective actuarially sound capitation rates that would appropriately consider the impact of COVID-19 on Medicaid cost and utilization. HHSC did not include these costs in the capitation rates and paid COVID-19 costs through a non-risk arrangement.

The rate changes varied by managed care program, MCO, region, and risk group, with an aggregate average rate decrease of approximately 2 percent compared to the federal fiscal year 2022 capitation rates. This figure excludes the impact of mid-year revisions to the capitation rates. HHSC submitted fiscal year 2023 rate amendments for additional changes needed to ensure that the State is paying actuarially sound capitation rates.

DY12 Q4 July – September 2023

Figure 8. Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (July 2023)	Month 2 (Aug 2023)	Month 3 (Sep 2023)	Total for Quarter Ending 9/2023
Adults	769,073	755,778	568,444	2,093,294
Children	3,636,836	3,540,430	3,388,781	10,566,047
AMR	381,953	379,951	377,689	1,139,593
Disabled	428,150	428,714	429,148	1,286,012

* These data are provided by HHSC Forecasting.

Figure 9. Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (July 2023)	Month 2 (Aug 2023)	Month 3 (Sep 2023)	Total for Quarter Ending 9/2023
Foster Care	49,503	49,460	49,459	148,423
Medically Needy	50	52	52	154
CHIP-Funded	266,169	255,725	236,493	758,387
STAR+PLUS 217-Like HCBS	16,026	16,020	16,069	48,115
Presumptively Eligible Pregnant Women	73	73	72	217

* These data are provided by HHSC Forecasting.

Anticipated Changes to Financial/Budget Neutrality

These STCs set forth a base year of federal fiscal year 2023 to be used in the first rebasing exercise. These terms identified adjustments for the base year and projected expenditures in Attachment U, inclusive of the proposed directed payment programs as a part of the DSRIP transition. The waiver reflects a DSRIP pool ending date of September 30, 2021, and the transition to directed payment programs starting September 1, 2021.

Texas Medicaid expenditures in federal fiscal year 2023, the base year, in conjunction with cost trends and adjustments will set the annual expenditure limit for the remainder of the 10-year waiver term.

11. Demonstration Operations and Policy

Medicaid Managed Care

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

- Expand risk-based managed care to new populations and services.
- Support the development and maintenance of a coordinated care delivery system.
- Improve outcomes while containing cost growth.
- Transition to quality-based payment systems across managed care and providers.

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

HHSC and the Medicaid MCOs achieved the following MMC milestones in federal fiscal year 2023 quarter four, including:

- HHSC submitted the HCBS settings statewide transition plan (STP) to CMS, and CMS provided final approval in July 2023. HHSC has worked with CMS to develop a CAP for any remaining areas of non-compliance with the HCBS Settings Rule. The CAP outlines remediation activities to be completed by September 1, 2025.

Challenges successfully navigated during federal fiscal year 2023 quarter four include:

- Activities related to the end of continuous coverage for individuals receiving continuous Medicaid coverage because of the COVID-19 PHE.
- Final approval of HHSC's HCBS settings STP from CMS. HHSC also responded to CMS' heightened scrutiny site visit report.

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

- Transitioning Healthy Texas Women to managed care.
- Coming into full compliance with the home and community-based settings regulations.
- Implementing a policy change to better serve medically fragile adults.
- Transitioning Medicaid-only services for dually eligible managed care members from a fee-for-service to a managed care service delivery system, as required by the 88th Legislative Session General Appropriations Act (GAA) 2024-2025, House Bill (H.B.) 1, Art. II, Rider 32.

Procurement Activities

HHSC has created a plan to procure new contracts for STAR+PLUS, STAR, and STAR Kids according to the estimated timeline below.

STAR+PLUS

- In accordance with 1 Texas Administrative Code (TAC) §391.219, HHSC issued a Notice of Award to the following Respondents:
    - United Healthcare Community Plan of Texas, LLC. – Bexar, Central Texas, Dallas, Harris, Hidalgo, Northeast Texas, Tarrant, and Travis Service Areas
    - Molina Healthcare of Texas, Inc. – Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Northeast Texas, and Tarrant Service Areas
    - Superior HealthPlan, Inc. – Central Texas, Dallas, Hidalgo, Lubbock, Nueces, Travis, and West Texas Service Areas
    - Amerigroup Insurance Company – Jefferson, Lubbock, Nueces, and West Texas Service Areas
    - Community First Health Plans, Inc. – Bexar Service Area
    - El Paso Health – El Paso Service Area
    - Community Health Choice Texas, Inc. – Harris Service Area
- Start of Operations: September 1, 2024

STAR

- Request for Proposals (RFP) Posted: December 7, 2022
- Estimated Notice of Award: Q1 State Fiscal Year 2025
- Start of Operations: Q1 State Fiscal Year 26

STAR Kids

- RFP Posting: Q3 State Fiscal Year 24
- Estimated Notice of Award: Q1 State Fiscal Year 2026
- Start of Operations: Q1 State Fiscal Year 2027

12. Litigation Summary

Type of Consideration	*Ongoing litigation-September 1, 1993*
Summary of Consideration	*Frew, et al. v. Young, et al.* (commonly referred to as *Frew*), was filed in 1993, and was brought on behalf of children under age 21 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the Federal Medicaid Act. The lawsuit was settled by a consent decree in 1996. The decree requires numerous State obligations and is monitored by the Court. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to eleven corrective action orders (CAOs) to bring the State into compliance with the consent decree and to increase access to EPSDT benefits. Currently, five of the eleven corrective action orders and their related consent decree paragraphs are fully dismissed: (1) Check-Up Reports and Plans for Lagging Counties, (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, (3) Transportation Program, (4) Health Care Provider Training, and most recently, (5) Outreach and Informing. Part III of the Managed Care CAO and portions of the Adequate Supply of Providers CAO have also been dismissed. In 2014, the parties jointly agreed to vacate most of the Toll-Free Numbers corrective action order, and the related consent decree paragraphs. One toll-free number remains under the corrective action order and court monitoring.
Date and Report in Which Consideration Was First Reported	The lawsuit was filed on September 1, 1993. The consent decree was entered on February 20, 1996. The eleven corrective action orders were entered on April 27, 2007.
Summary of Impact	The consent decree and corrective action orders touch upon many program areas, and generally require the State to take actions intended to ensure access, or measure access, to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons under

	age 21.
Estimated Number of Beneficiaries	Estimated (as of March 2023) at 4,399,092.
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.

Type of Consideration	*Ongoing litigation-June 8, 2023*
Summary of Consideration	*Cascades at Galveston Rehab, LP, et al* was filed on June 8, 2023. Plaintiffs, Cascades at Galveston and Cascades at Jacinto, are nursing facilities who allege that HHSC wrongfully recouped QIPP State Fiscal Year (SFY) 2022 funds. Plaintiffs filed this lawsuit appealing HHSC's recoupment. Plaintiffs allege that the actions taken by HHSC were unconstitutional by failing to allow for due process of law, were without regulatory authority, and were in excess of HHSC's statutory authority. HHSC has filed an answer to this lawsuit, denying all allegations. The Office of Attorney General (OAG) will file a plea to the jurisdiction ("PTJ") in late October or early November. If the court agrees fully with the PTJ, the case would be dismissed.
Date and Report in Which Consideration Was First Reported	The lawsuit was filed on June 8, 2023. HHSC's answer was filed on July 14, 2023.

Type of Consideration	*New litigation-November 7, 2023*
Summary of Consideration	On November 7, 2023, Wellpoint Insurance Company, formerly known as Amerigroup Insurance Company, filed a petition for injunctive relief in Travis County District Court against the Executive Commissioner (EC) in her official capacity, alleging that the EC acted in violation of state law when awarding contracts to MCOs for the STAR+PLUS Medicaid program. Wellpoint is asking the court to order HHSC to award them STAR+PLUS contracts in the Harris, Bexar, and El Paso Service areas.
Date and Report in Which Consideration Was First Reported	The lawsuit was filed on November 7, 2023. HHSC will file an answer by December 11, 2023.

13. Health IT

Health Information Exchange (HIE) Connectivity Project Update

The HIE Connectivity Project is a Texas Medicaid initiative supported by CMS and state funds. The project consists of three strategies. Successful implementation of the three strategies will result in increased HIE adoption by Medicaid providers, creation of new HIE capacity in Texas, bring clinical information into the Texas Medicaid program through HIE, and benefit Medicaid beneficiaries. The following is an update regarding progress made for each strategy, as well as another CMS-funded initiative, the Patient Unified Look-up System for Emergencies (PULSE).

HIE IAPD Strategies 1-3

Strategy 1/Medicaid Provider HIE Connectivity: As of September 30, 2023, 534 providers are currently approved through Strategy 1 to join with the three local HIEs: C3HIE (formerly known as HASA), Greater Houston Healthconnect (GHH), and Connected Care Exchange (formerly Rio Grande Valley HIE). Providers onboarded to the project belong to 124 ambulatory practices, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), and 50 hospitals.

Strategy 2/Texas HIE Infrastructure: Maintenance and enhancement of connectivity between participating local HIEs and Texas Medicaid, via the Texas Health Services Authority (THSA's) HIETexas, is ongoing. The framework for the exchange, transport, integration, and retrieval of electronic health information between and among healthcare entities continues to be supported. HIETexas continues to support a user interface for individuals designated by HHSC, integration work and technical assistance for local HIEs, as well as activities and capabilities required for C-CDA Transition of Care summaries and Emergency Department Encounter Notification (EDEN) ADT alerts delivered to Texas Medicaid.

Thus far, patient census information has been automatically obtained and ingested via the EDEN software platform for query services. This has included the capability to query and retrieve documents from HIE networks at the local and national level. These queried documents are then forwarded to Texas Medicaid. HIETexas is converting to a new process in fall of 2023, through which local HIEs will push C-CDAs to HIETexas via the Redox platform. HIETexas will then push C-CDAs to Texas Medicaid. Through this process, data mapping across the 3 contracted local HIEs will better standardize the data received by Texas Medicaid.

Strategy 3/EDEN System: In addition to those providers and hospitals onboarded to the project via Strategy 1, C3HIE sends ADT alerts from all existing hospital connections (total of 42 with four more in progress). Additionally, THSA is making direct connections with hospitals, urgent care facilities, and Skilled Nursing Facilities (SNFs)/rehabs. As of September 30, 2023, THSA has made direct connections to 132 hospitals and urgent care facilities. Eighty-nine direct connections are in progress and data subscribers, including hospitals, ambulatory practices, and Medicaid Managed Care Organizations, continue to be added. ADT alerts via the local HIEs and THSA's direct hospital connections continue to be received through HIETexas and sent to Texas Medicaid. ADTs via direct connections and C3HIE are also sent to EDEN subscribers. HHSC is in the process of analyzing and mapping project data, which will be made accessible and usable to various departments and program areas within HHS.

PULSE

PULSE infrastructure, which interconnects disparate health information from multiple sources in response to a disaster, continues to operate and has been ready for use during the 2023 hurricane season. PULSE allows authorized users to query clinical data, support patient reunification efforts, and search public health emergency patient data. The HIETexas PULSE system is being maintained and prepared to be activated in the instance of a declared disaster in Texas.

The PULSE system has maintained 100% uptime this calendar year, and THSA continues to provide PULSE demonstrations for end users.

On September 7, 2023, HHSC went through CMS Certification Review for the PULSE system and HIE Connectivity Project's Strategies 2 and 3.

14. Evaluation

HHSC completed the following 1115 Waiver evaluation activities during Federal Fiscal Year 2023 (DY12), Quarter four:

- HHSC attended Texas A&M University's (TAMU) two-day waiver workshop on preliminary findings from the forthcoming Interim Report #1, covering DYs 7-11, on July 27-28, 2023.
- HHSC attended a virtual quarterly meeting with TAMU on August 25, 2023, to discuss progress on the final report along with contract updates for DYs 10-19.
- HHSC and TAMU continued progress on the contract for the Evaluation Design covering DYs 10-19. HHSC sent the initial contract to TAMU on September 1, 2023. The contract was in the final stages of review at the end of Quarter Four. HHSC anticipates the contract will be executed early in Federal Fiscal Year 2023, Quarter One (beginning of DY13).

HHSC completed the following 1115 Waiver evaluation activities during Federal Fiscal Year 2023 (DY12):

- HHSC received CMS approval on Revision 6.1 of the 1115 Evaluation Design covering DYs 7-11 (2017 STCs), which reflects plans for the Interim Evaluation Report #1 (due on March 31, 2024), on March 17, 2023.
- HHSC reviewed TAMU's preliminary findings for Interim Report #1 during a two-day waiver workshop in July 2023.
- TAMU signed a Letter of Intent and Termination Notice on May 16, 2023. These documents indicate TAMU's commitment to executing the Evaluation Design covering DYs 10-19.

Modifications to the Evaluation Design

HHSC did not make modifications to the 1115 Evaluation Designs during Federal Fiscal Year 2023, quarter four.

Description of Evaluation Findings or Reports

CMS approved TAMU's revised Interim Report on August 2, 2022. Key takeaways from the Interim Report were described in the Annual Monitoring Report for DY 10. Additional evaluation findings will be summarized after the Interim Evaluation Report #1 is submitted (due on March 31, 2024).

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

Table 7. Evaluation-related Deliverables

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Evaluation Design Plan (2017 STCs)	N/A	CMS approved the Evaluation Design on 8/2/2018.	N/A
Obtain Independent External Evaluator (2017 STCs)	N/A	HHSC executed the contract with TAMU on 8/31/2019.	N/A

Interim Evaluation Report (2017 STCs)	N/A	CMS approved TAMU's revised Interim Report to CMS on 8/2/2022.	N/A
Evaluation Design Plan (2021 STCs)	N/A	CMS approved the Evaluation Design on 5/26/2022.	N/A
Obtain Independent External Evaluator (2021 STCs)	9/1/2023[1]	HHSC received a signed Letter of Intent and Termination Notice from TAMU on 5/16/2023 confirming their intent to serve as the external evaluator for the waiver extension. HHSC sent the evaluation contract to TAMU on 8/01/2023.	*No issues anticipated at this time; the contract is under final review and will be executed in the near future.*
Interim Evaluation Reports (2021 STCs)	3/31/2024[2]; 3/31/2027; 9/30/2029		*No issues anticipated at this time*
Summative Evaluation Report (2021 STCs)	3/30/2032		*No issues anticipated at this time*

Notes. [1] Obtaining an external evaluator was originally slated to be completed by 5/26/2023. However, due to budgeting and contract considerations, HHSC updated this date to 9/1/2023. [2] Interim Evaluation Report #1 under the 2021 STCs replaced the Summative Evaluation Report previously required under the 2017 STCs.

15. Charity Care Pools

Uncompensated Care Pool

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

Public Health Provider Charity Care Pool

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

16. Post Award Forum

The following is a summary of the post-award forum as required for the annual report. This summary was also provided in the Quarter 3 report. In compliance with STC 79, and as part of the Medical Care Advisory Committee (MCAC) meeting, HHSC hosted a public post-award forum in-person with a virtual attendance option on June 8, 2023, to provide the public with an annual update on progress of the THTQIP waiver. The public forum was held at the Winters Building Public Hearing Room, 701 W. 51st Street Austin, TX 78751. The date, time, and location of the public forum were published on HHSC's website 30 days in advance of the meeting.

During the June 2023 post-award public forum, HHSC provided the public with an update on the following Transformation waiver topics: evaluation design plan, amendments update, end of continuous Medicaid coverage, legislative update, supplemental payments, directed payment programs (DPPs), and budget neutrality. A link to the 1115 DY11 annual report was also provided to the public. The presentation and agenda were posted to the HHSC website.

HHSC received one written comment from the following stakeholder: Texas Hospital Association. The stakeholder commented on support for the THTQIP waiver program and HHSC's effort to redetermine eligibility for 2.7 million Medicaid enrollees in continuous coverage following the end of the public health emergency. The stakeholder indicated appreciation of HHSC obtaining re-approval of five DPPs for state fiscal year 2023. The stakeholder expressed ongoing support for:

- Securing a favorable budget neutrality determination in the ongoing rebasing exercise;
- Gaining approval for HHSC's pending proposal to modify the years of claims and encounter data used in the second UC resizing;
- Securing FY 2024 DPP approvals from CMS;
- Fully implementing an extension of postpartum coverage to 12 months following the end of pregnancy;
- Continuing to reinforce the behavioral health safety net; and
- Ongoing refinement of hospital quality initiatives in Medicaid.

17. Report Attachments

Attachment A - Managed Care Organizations by Service Delivery Area. The attachment includes a table of the health and dental plans by Service Delivery Area.
Attachment B1 - Enrollment Summary. The attachment includes quarterly Dental, STAR, STAR Kids and STAR+PLUS enrollment summaries.
Attachment B2 - Medicaid Enrollment Reports. Includes Medicaid Enrollment Reports from December 2022 through February 2023.
Attachments C1, C2, C3 - Provider Network and Methodology. These 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 attachment summarizes Dental, STAR, STAR Kids, and STAR+PLUS out-of-network utilization.
Attachment E - Distance Standards. The attachment shows the State's distance standards by provider type and county designation.
Attachments H1 - H4 - Network Access Analysis. The attachments include the results of the State's analysis for PCPs, main dentists, and specialists.
Attachment J – MCO Pharmacy GeoMapping Summary. The attachment includes the STAR, STAR Kids, and STAR_PLUS plans' self-reported GeoMapping results for pharmacy.
Attachments K1, K2, K3, K4, K5, K6, K7, K8, K9, K10, K11 – State Direct Programs. The attachments display QIPP uniform rate increase and value-based payments, Nursing Facility Claims Minimum Fee Schedule including QIPP NF funds earned per Metric, UHRIP rate increase, and Rural Hospital MCO Encounter Minimum Fee Schedule.
Attachments M1 - M4 - Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.
Attachment N - MCO Appeals. The attachment includes Dental, STAR, STAR Kids, and STAR+PLUS appeals received by MCOs.
Attachment O - HHSC and MCOs self-reported Complaints. The attachment includes information concerning Dental, STAR, STAR Kids, and STAR+PLUS complaints received by the State and MCOs.
Attachment P - Budget Neutrality. The attachment includes actual expenditure and member-month data as available to track budget neutrality.
Attachment Q – Service Coordination Report. The attachment outlines STAR MSHCN, STAR Kids, and STAR+PLUS details by SDA and MCO.
Attachments R1, R2 - Provider Fraud and Abuse. The attachments represent a summary of the referrals that STAR, STAR Kids, STAR+PLUS, and Dental Program plans sent to the OIG.
Attachment S - Service Utilization. The attachment displays Enrollment and Expenditure Graphs for the previous fiscal year.
Attachments V1 - V4 - Claims Summary. The attachments are summaries of the MCOs' claims adjudication results.