Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly, Biannual, and Annual Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2014 State Fiscal Quarter 4, June-August

Demonstration Year (DY) 3 October–September

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I. INTRODUCTION

Through the Texas Healthcare Transformation and Quality Improvement Program Section 1115 waiver, the state is able to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population; and
- Transition to quality-based payment systems across managed care and hospitals.

This report documents the state's progress in meeting these goals. It addresses the quarterly, bi-annual, and annual reporting requirements for the STAR and STAR+PLUS programs, as well as Children's Medicaid Dental Services (Dental Program), which are found in the waiver's Special Terms and Conditions (STCs), items 14, 20, 24(e), 39(a) (b) and (c), 40(b) and (c), 52, 65, and 66, and 67. These STCs require the state to report on various topics, including: enrollments and disenrollments; access to care; anticipated changes in populations or benefits; network adequacy; encounter data; operational, policy, systems, and fiscal issues; action plans for addressing identified issues; budget neutrality; member months; consumer issues; quality assurance and monitoring; Demonstration evaluation; and Regional Healthcare Partnerships (RHPs). STC 66 requires the State to report on various topics, including: accomplishments, project status, quantitative, and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The Program Funding and Mechanics Protocol also require the State to submit an annual report to CMS.

The State collects performance and other data from its managed care organizations (or "plans") on a State Fiscal Quarterly (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2014 state fiscal quarter (SFQ) 4 (June-August) instead of Demonstration Year (DY) 3, Q4 ("2014 D4," covering July-September). Throughout the report, the State has identified whether the quarterly data relates to 2014 SFQ4 or 2014 D4.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2014 D3, the State contracted with 18 STAR, 5 STAR+PLUS, and 2 Dental program plans. Each health plan covers one or more of the 13 STAR service areas or 10 STAR+PLUS service areas, and each dental plan provides statewide services. Please refer to Attachment A for a list of the STAR, STAR+PLUS, and Dental plans by area.

B. MONITORING HEALTH PLANS

HHSC staff evaluates and routinely monitors MCO performance reported by the MCOs or compiled by HHSC. If an MCO fails to meet a performance expectation, standard, schedule, or other contract requirement such as failing to provide a deliverable on time or at the level of quality required, the managed care contracts give HHSC the authority to use a variety of remedies, including:

- Monetary damages (actual, consequential, direct, indirect, special, and/or liquidated damages (LD)
- Corrective action plans (CAPs)

C. DEMONSTRATION FUNDING POOLS

The Section 1115 demonstration establishes two funding pools, created by savings generated from managed care expansion and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating providers that implement and operate delivery system reforms.

Texas worked with private and public hospitals, local government entities, and other providers to create RHPs that are anchored by public hospitals or other specific government entities. RHPs identified performance areas for improvement that may align with the following four broad categories to be eligible for incentive payments: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements, and (4) population focused improvements. The non-Federal share of funding for pool expenditures is largely financed by State and local intergovernmental transfers (IGTs).

Waiver activities are proceeding and detailed information on the status is included in the sections below.

II. ENROLLMENT AND BENEFITS INFORMATION

This section addresses STCs 24(e), 39(a), 52, 65, 67, including quarterly and biannual trends and issues related to STAR, 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. Unless otherwise provided, quarterly managed care data covers the 2014 SFQ4 reporting period (June – Aug) instead of 2014 D3 (July – Sep). Supporting data is located in Attachments B and Q.

A. ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 24(e) and 65. As of June 2014, managed care enrollments under the 1115 approached three million members. Attachment B includes enrollment summaries for the three managed care programs.

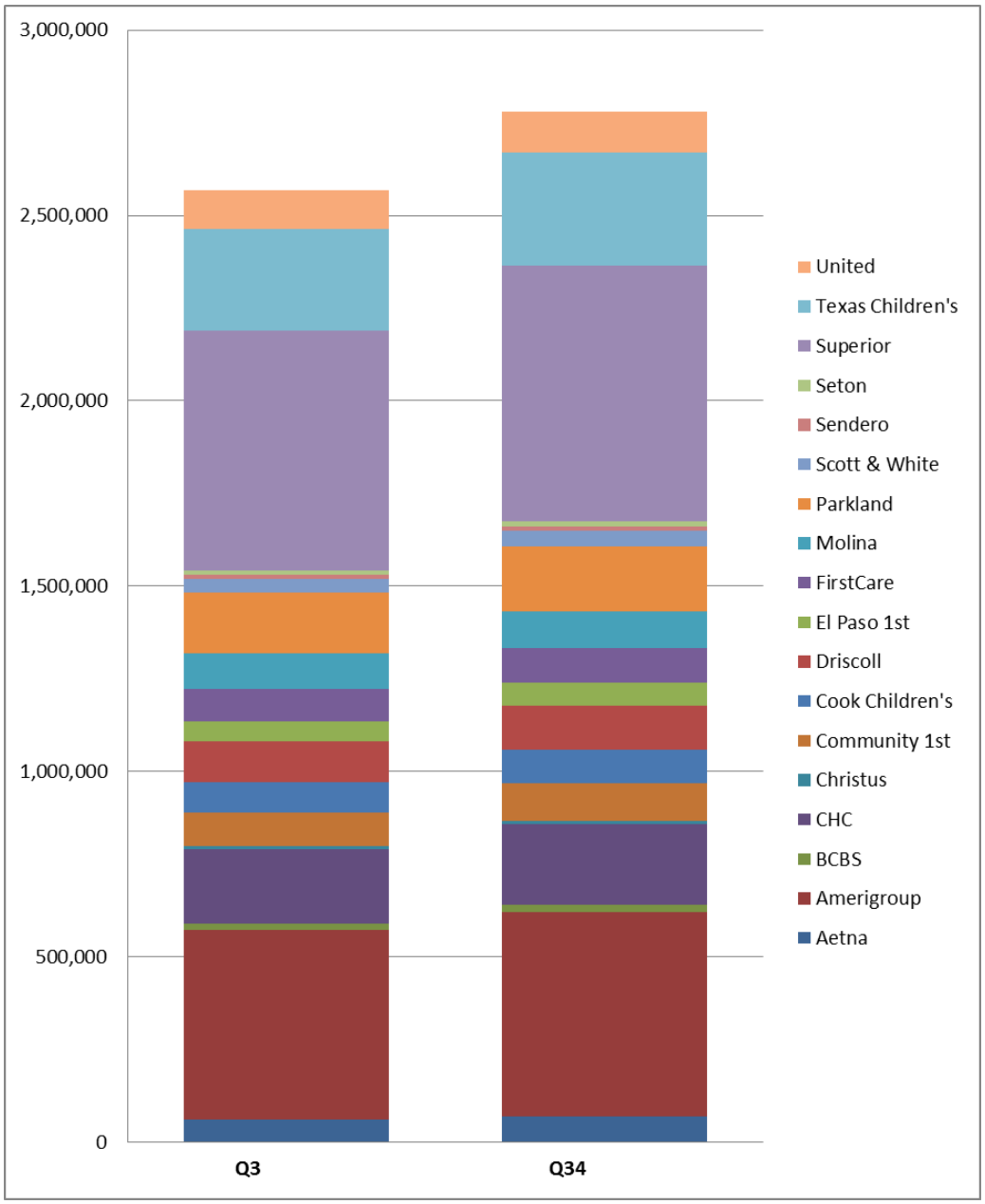
Overall, the Texas Medicaid managed care programs, Dental, STAR and STAR+PLUS, grew by 7.60 percent in 14SFQ4. Enrollment in all STAR MCOs and both Dental plans grew from SFQ3 to SFQ4. Enrollment in the STAR+PLUS MCOs varied between a reduction of 0.46 percent and an increase of 1.43 percent.

1. Market Share and Enrollment Growth

The number of members enrolled in STAR plans increased 8.34 percent from 2,567,007 in SFQ3 to 2,781,008 in SFQ4. Across the state, the largest increase in market share occurred within Blue Cross Blue Shield and Sendero, for which enrollment increased by 17 and 15 percent, respectively, in SFQ4. A possible explanation for this increase is that members may not have lost eligibility or enrolled with alternate MCOs during the quarter.

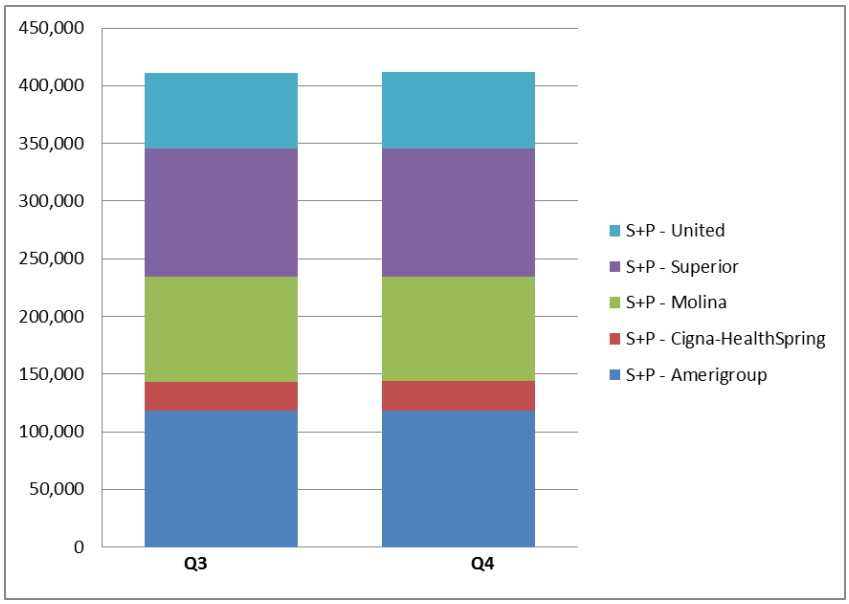
STAR program enrollment increased between SFQ3 and SFQ4. By service delivery area (SDA), the largest enrollment gains occurred in Tarrant SDA, in which Aetna, Cook, and Amerigroup increased by 11, 10, and 8 percent respectively, similar to last quarter. Other notable enrollment increases in STAR occurred in Travis SDA (10.61 percent) and Dallas SDA (9.03 percent). No STAR SDAs lost membership between SFQ3 and SFQ4.

Figure 1: STAR Enrollment by Managed Care Plan (2014 Q3-Q4)



The number of members enrolled in STAR+PLUS plans increased by 0.25 percent from 411,069 in SFQ3 to 412,110 in SFQ4. Four of the five MCOs gained members in SFQ4. STAR+PLUS had insignificant enrollment changes by SDA, ranging from minus 0.49 percent to 0.84 percent.

Figure 2: STAR+PLUS Enrollment by Managed Care Plan (2014 Q3-Q4)



Overall market share by MCO remained steady compared to the previous quarter, shown in the graph below. Gains and losses of market share varied within half a percentage point. Amerigroup and Superior health plans hold the largest market share, at 20.95 percent and 25.02 percent in SFQ4, with Texas Children's as the third largest with 9.59 percent.

Enrollment Market Share by MCO (2014 Q4)

MCO	Enrollment	Market Share
Aetna	68,600	2.15%
Amerigroup	668,948	20.95%
BCBS	20,285	0.64%
CHC	219,128	6.86%
Christus	7,039	0.22%
Cigna-HealthSpring	25,117	0.79%
Community 1st	101,404	3.18%
Cook Children's	92,082	2.88%
Driscoll	119,183	3.73%
El Paso 1st	60,384	1.89%
FirstCare	93,712	2.93%
Molina	190,664	5.97%
Parkland	176,066	5.51%
Scott & White	41,555	1.30%
Sendero	11,306	0.35%
Seton	14,846	0.46%

Superior	799,042	25.02%
Texas Children's	306,230	9.59%
United	177,527	5.56%
Grand Total	**3,193,118**	**100.00%**

The two figures below show enrollment by program, SDA, and MCO in the last three quarters of 2014.

Figure 3: STAR Program Enrollment by MCO and Service Area (2014)

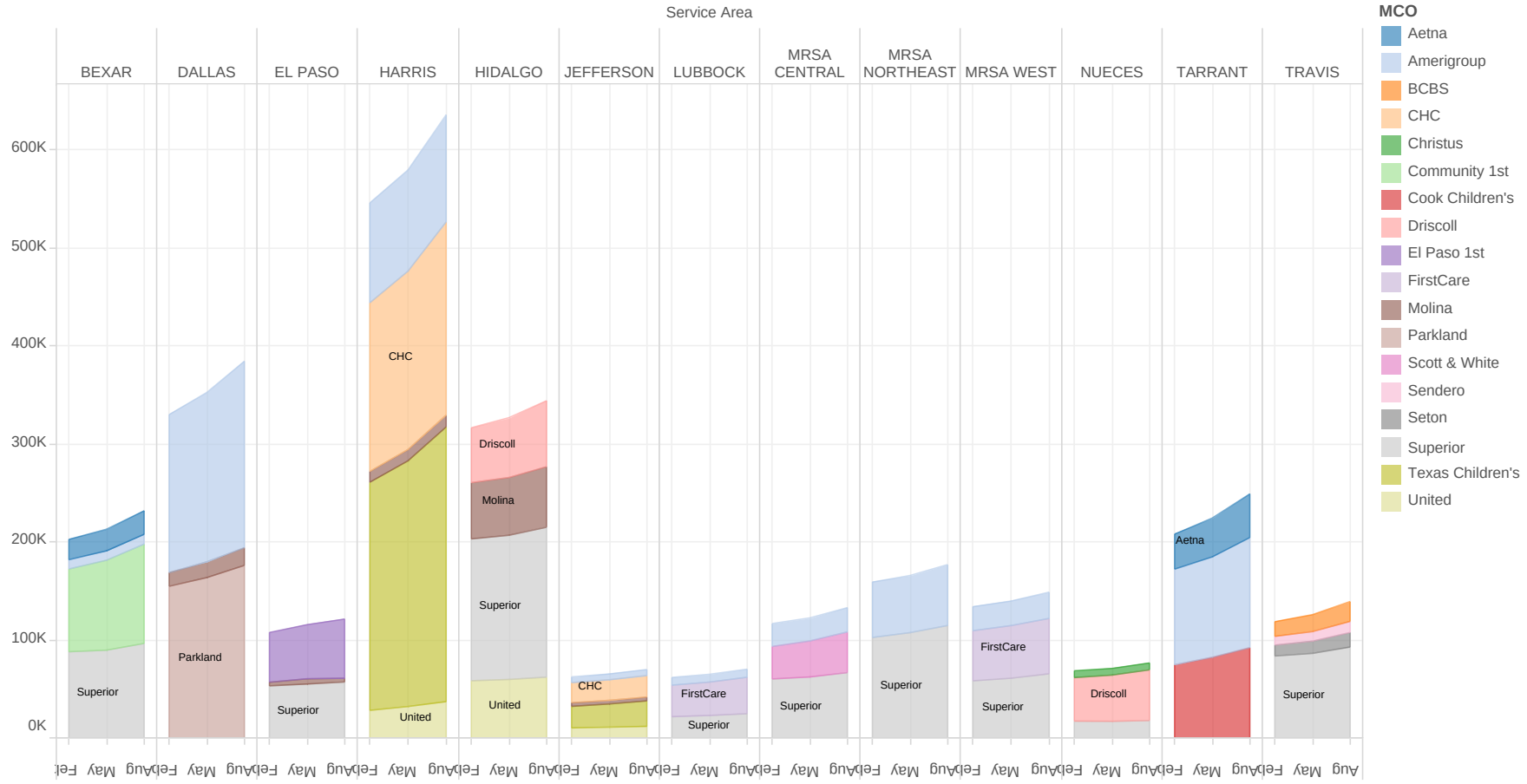
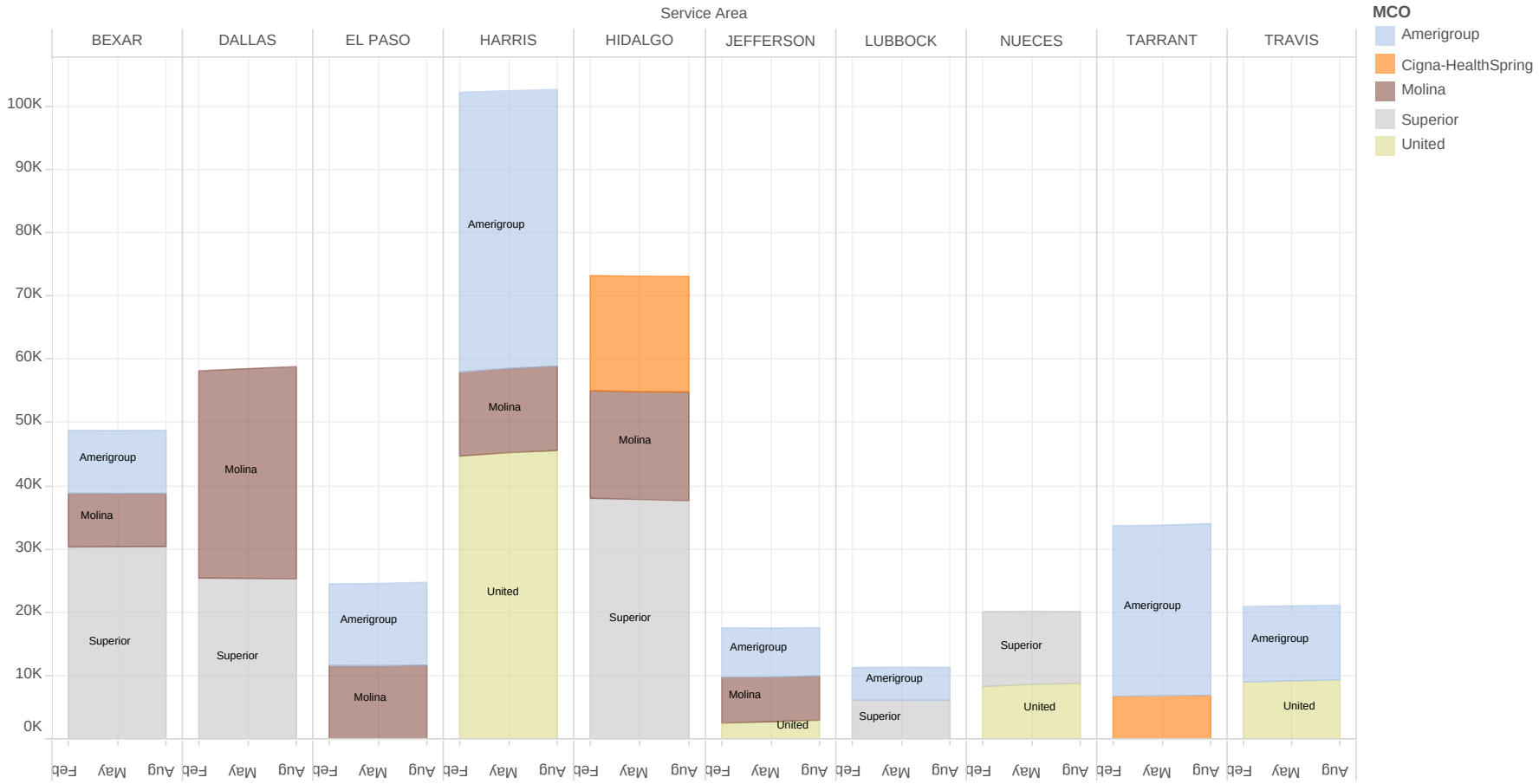


Figure 4: STAR+PLUS Program Enrollment by MCO and Service Area (2014)



Total enrollment in the Dental program increased by 8 percent to 2,742,976 members in SFQ4. Both DentaQuest and MCNA enrollments increased by approximately eight percent each between SFQ3 and SFQ4.

2. Enrollment of People with Special Healthcare Needs

The state's Medicaid application asks potential enrollees to identify any family members that have special health care needs (MSHCN). MSHCN means a member including a child, or children with special health care needs (CSHCN) who (1) has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and (2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel. The state's enrollment broker conveys this and other information concerning potential members with special healthcare needs (MSHCN) to health and dental plans, who then verify whether the members meet the plans' assessment criteria for MSHCN. All STAR+PLUS members and Former Foster Care Children (FFCC) enrolled in STAR are deemed to be MSHCN.

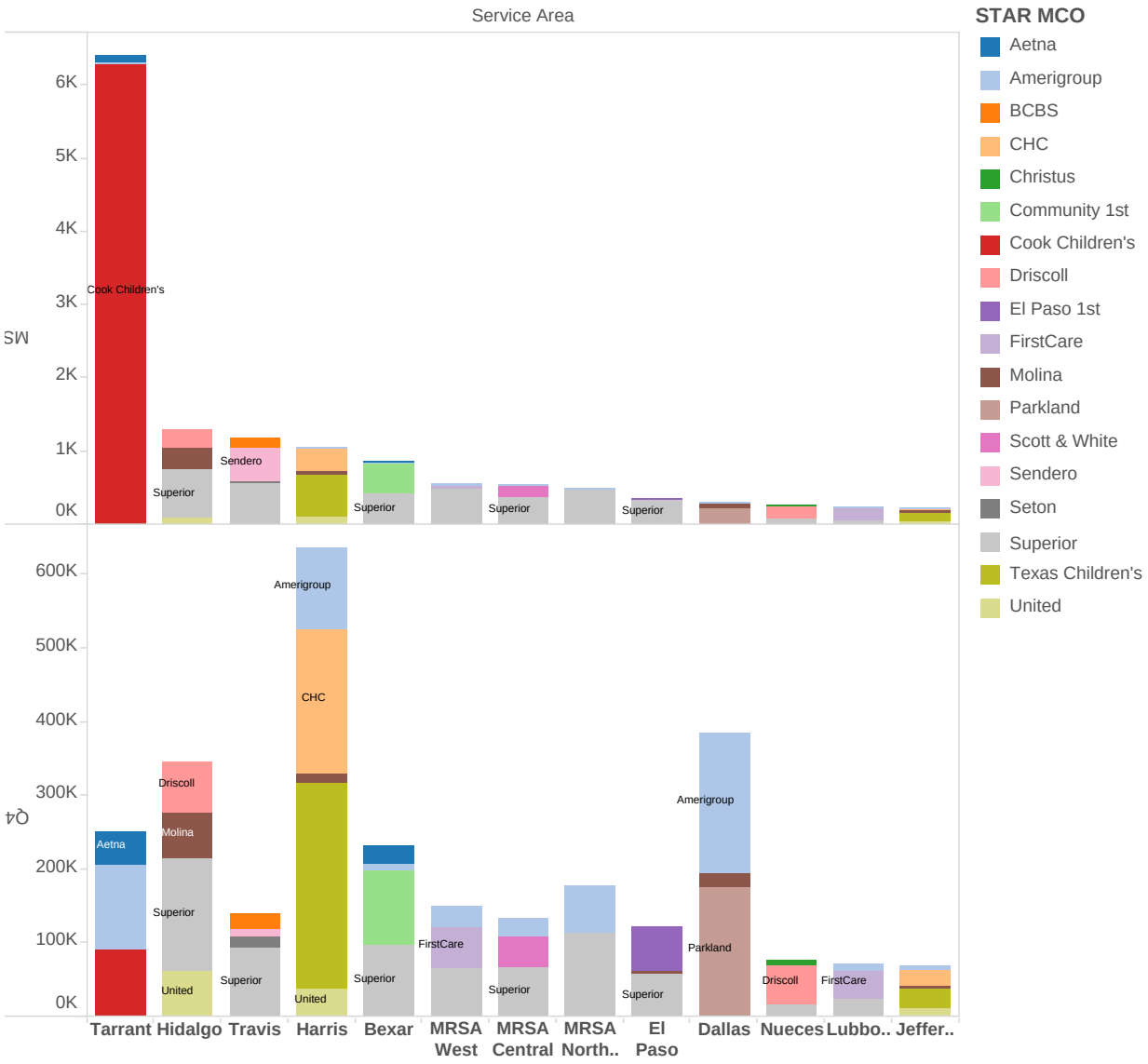
Health and dental plans must also develop their own processes for identifying MSHCN, including CSHCN and others with disabilities or chronic or complex medical and behavioral health conditions.

In the past, HHSC has provided MSHCN data provided by the enrollment broker in the annual reports. This data showed the number of self-identified MSHCN for the quarter, and did not reflect the total number of verified MSHCN. HHSC requested MCOs to submit the total number of MSHCN that they have verified in the last quarter of 2014. The data presented in Attachment Q of this report shows a snapshot of the total number of MSHCN for the month of August 2014.

Attachment Q shows that the plans are properly reporting the total number of STAR+PLUS MSHCN. All STAR+PLUS plans reported 100 percent MSHCN, as required in the contract.

The figure below shows in August 2014, there were a total of 13,768 children and adults that were verified to have special healthcare needs by a STAR MCO. Less than one percent (0.50 percent) of all STAR members were verified by an MCO to have a special health care need. Tarrant and Travis SDAs had the greatest percent of members with special health care needs; all other SDAs reported less than two percent of MSHCN. The majority of plans identified less than one percent of its members as MSHCN. The two exceptions were STAR Cook Tarrant (6.85 percent) and STAR Sendero Travis (4.17 percent).

Figure 5: Total Number of STAR Members Identified as MSHCN and Total STAR Enrollment by MCO and SDA (2014 Q4)



STAR MCOs rely on various mechanisms to identify and verify MSHCN in addition to member self-identification. For example, Cook relies on a combination of member screening and predictive modeling to identify members. Sendero identifies members as MSHCN if they meet specific diagnosis criteria. Most STAR MCOs employ a combination of methods including provider referrals, risk assessments, and utilization reviews. Only a couple of STAR MCOs use predictive modeling and specific diagnosis criteria. HHSC does not provide MCOs a definitive list of conditions that should be included in MSHCN criteria.

HHSC is working to strengthen MCO requirements related to MSHCN. HHSC is revising the current managed care contract to clarify the populations that must be identified as MSHCN. The new language will also provide requirements for service management and service plans. If approved, the changes will be effective on March 1, 2015. In the future, HHSC will create a report to track MSHCN and plan activity surrounding these members as well as conduct audits of service plans to make sure that members receive appropriate services.

B. ENROLLMENT COUNTS FOR THE QUARTER BY POPULATION

This section includes quarterly enrollment counts, as required by STC 65. Due to the time required for the data collection process, unique client counts per quarter are reported on a two quarter lag. The following table includes enrollment counts for the 2014 Federal Fiscal Quarter 1. Enrollment counts are based on persons, and not member months.

Enrollment Counts for (Jan – Mar 2014)

Demonstration Populations	Total Number
Adults	317,485
Children	2,542,206
Aged and Medicare Related (AMR)	306,735
Disabled	439,883

Approximately 100,000 individuals transitioned from fee-for-service to STAR+PLUS in the Medicaid Rural Service Areas (MRSA), including individuals with Intellectual and Developmental Disabilities (IDD). Approximately one half of those transitioning to managed care selected to enroll with a particular MCO; the rest were auto-assigned by the state.

Population	Choice Rate
MRSA	52%
MRSA IDD	63%
MRSA Non-IDD	52%
IDD statewide	54%

C. MEDICAID ELIGIBILITY CHANGES

Effective January 1, 2014, the Affordable Care Act required states to determine financial eligibility for most individuals in Medicaid and the Children's Health Insurance Program (CHIP) using modified adjusted gross income (MAGI) methodologies, to change other eligibility determination policies and processes for Medicaid and CHIP, coordinate eligibility

determinations between Medicaid and CHIP and the Health Insurance Marketplace, and mandated coverage of certain populations. HHSC amended the Texas Healthcare Transformation and Quality Improvement Program (1115 waiver) to include the federally-required Medicaid populations: children ages 6 through 18 with incomes from 100-133 percent of the Federal Poverty Level (FPL) and former foster care youth up to the age of 26. Additionally, for the MAGI populations which includes pregnant women, children and families, the waiver was amended to apply rules established and approved by CMS in order to determine income and household composition. Asset tests and most income disregards were prohibited, but a five percentage point across-the-board income disregard was applied.

With the exception of the conversion to a MAGI standard effective January 1, 2014, and the populations outlined below, no additional eligibility changes were made to the 1115 waiver populations. The charts below provide enrollment numbers of ACA populations in managed care, in compliance with STC 67.

- Former Foster Care Children - mandatory managed care for 18-26
    - Ages 18 through 20: choice between STAR Health and STAR program.
    - Ages 21 through 26: Mandatory STAR.

Month	Enrollment Count
June	375
July	448
August	523

- Children ages 6 through 18 with incomes from 100-133 percent
    - Mandatory managed care - STAR program

Month	Enrollment Count
June	106,994
July	133,327
August	149,574

D. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

Effective March 1, 2015, HHSC will carve in nursing facility services to STAR+PLUS.

Also effective March 1, 2015, under the Dual Demonstration, HHSC will test an innovative delivery model that combines health services for people with both Medicaid and Medicare coverage into one plan. The demonstration will include full-dual eligible adults (age 21 and

above) who reside in a STAR+PLUS service area that currently receive their Medicaid benefits through the STAR+PLUS managed care program. One entity will be responsible for coordinating the full array of Medicaid and Medicare services. This includes any benefits that will be added to the STAR+PLUS service array by March 1, 2015, such as nursing facility services, psychosocial mental health rehabilitation and targeted case management. The demonstration will be implemented in the following six counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant and is anticipated to begin March 1, 2015. The goals of the demonstration are to improve quality and individual experience in accessing care and promote independence in the community.

Dependent upon CMS approval, beginning March 1, 2015, STAR+PLUS MCOs will be required to make Community First Choice (CFC) a benefit for certain individuals who meet an institutional level of care for an intermediate care facility for individuals with intellectual disabilities or a related condition (ICF-IID), nursing facility or Institution for Mental Disease (IMD) and upon assessment are determined to require attendant, habilitation, emergency response services (ERS) and/or support management.

Effective September 1, 2014, HHSC also implemented the following initiatives impacting the waiver managed care programs to create greater continuity of care for Medicaid clients and further coordinate and integrate physical, behavioral health, and acute care services with long term services and supports:

- Expansion of STAR+PLUS to the MRSA;
- Provision of mental health targeted case management and mental health rehabilitation services through Medicaid MCOs (except in the NorthSTAR service area);
- Addition of supported employment and employment assistance services to the STAR+PLUS home and community-based services program; and,
- Provision of acute care services through STAR+PLUS for members receiving services through a community-based intermediate care facility for individuals with intellectual disabilities or a related condition (ICF/IID), or an ICF/IID waiver.

Based in part on the above proposed and implemented changes, HHSC anticipates the following caseload changes in managed care enrollment as shown in the chart below.

Medicaid Average Monthly Caseload Forecasts (2014-2017)

Current World	FY 2014	FY 2015	FY 2016	FY 2017
Total FFS	735,000	733,000	751,000	771,000
Total Managed Care	3,3012,000	3,346,000	3,449,000	3,537,000
Total Medicaid	3,747,000	4,079,000	4,200,000	4,308,000

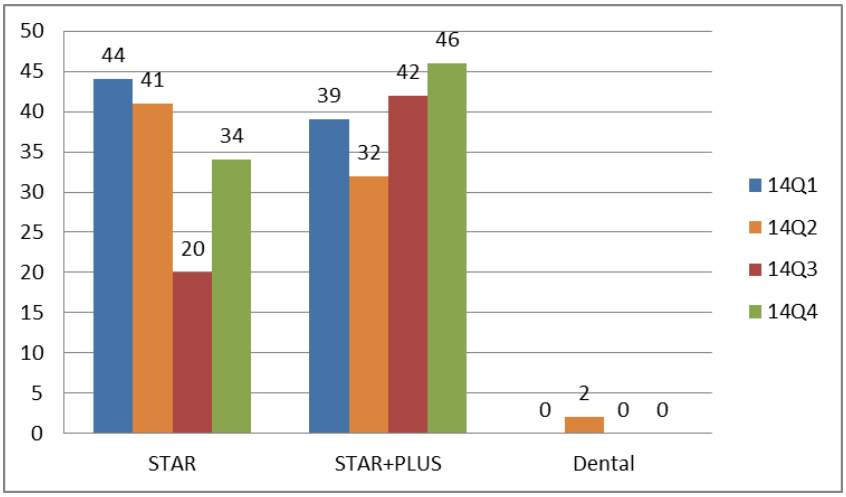
% Managed Care	*80%*	*82%*	*82%*	*82%*
After Expansions	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
Total FFS	735,000	552,000	496,000	351,000
Total Managed Care	3,012,000	3,527,000	3,704,000	3,957,000
Total Medicaid	3,747,000	4,079,000	4,200,000	4,308,000
% Managed Care	*80%*	*86%*	*88%*	*92%*

E. DISENROLLMENT FROM MANAGED CARE

This section of the report addresses STC 39(b).

In 2014 SFQ3 and SFQ4, the enrollment broker, MAXIMUS, reported 983 and 894 plan changes processed. Regarding disenrollment requests from Medicaid managed care to fee-for-service delivery model, the state received the following in SFQ3 and SFQ4: 54 disenrollment requests for STAR, 88 for STAR+PLUS, and none for the Dental Program. The figure below depicts total disenrollment requests from managed care by state fiscal quarter in 2014. Consistent with prior trends, members or their representatives initiated all disenrollment requests in SFQ3 and SFQ4. In total, two individuals were disenrolled from managed care in SFQ3 or SFQ4: one for residing in an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID), and one for residing in a nursing facility. The member that was disenrolled for moving to an ICF/IID was re-enrolled in managed care in October 2014 due to the IDD carve-in to STAR+PLUS effective September 1, 2014.

Figure 6: Managed Care Disenrollment Requests (2014)



As demonstrated in chart below, the ratio of disenrollment requests to members in managed care remained low in all three programs.

Ratio of Disenrollment Requests to Members (2014 Q3-Q4)

Program	SFQ3 Ratio	SFQ4 Ratio
STAR	1:128,350	1: 81,794
STAR+PLUS	1:9,787	1:8,958

DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly reporting requirements found in STCs 24(e), 39(a), 39 (c), and 65. Supporting data is located in Attachments C through K. HHSC routinely reviews various measures related to network adequacy, including those reported in the following section of this report: provider network counts, open panel, service utilization, geoaccess, provider availability and accessibility, and out-of-network utilization (OON). HHSC monitors these measures in combination with member complaints in order to assess the adequacy of MCO provider networks.

A. PROVIDER NETWORKS

This subsection includes quarterly healthcare and pharmacy provider counts for STAR and STAR+PLUS, and dental provider counts for the Dental Program. The provider network methodology is contained in Attachment C1 provider network counts are reported in Attachment C2.

1. Primary Care Providers (PCPs)

The STAR PCP counts grew by one percent in SFQ4. STAR+PLUS PCP counts grew significantly due to the expansion of STAR+PLUS in the MRSAs. Other than the MRSAs, the PCP counts in SDAs grew modestly. Only two MCOs experienced decreases in PCP provider counts: Christus and Parkland. Blue Cross Blue Shield of Texas counts grew by 11 percent. Across the state, the total number of PCP terminations in STAR and STAR+PLUS increased from SFQ3 to SFQ4. The most common reason reported by MCOs for provider termination was that the provider left group practice.

2. Specialists (non-pharmacy)

The STAR specialist counts grew by two percent in SFQ4. STAR+PLUS PCP counts grew significantly due to the expansion of STAR+PLUS in the MRSAs. Other than the MRSAs, most SDA PCP counts grew modestly, with the exception of two areas: Travis STAR grew by 24

percent due to growth in BCBS's network; Bexar STAR+PLUS grew by 12 percent due to growth in Molina's network. Across the state, the total number of PCP terminations in STAR and STAR+PLUS increased from SFQ3 to SFQ4. The most common reason reported by MCOs for provider termination was that the provider left group practice.

3. Pharmacy Providers

STAR and STAR+PLUS pharmacy networks increased across MCOs in SFQ4. STAR+PLUS pharmacy counts grew significantly due to the expansion of STAR+PLUS in the MRSAs.

4. Dental Program Provider Counts

The number of main and specialty dentists increased for DentaQuest by one percent between SFQ3 and SFQ4. MCNA's main and specialty dental networks decreased by two percent. Provider terminations were stable within MCNA but DentaQuest terminated more main and specialty dentists than the prior quarter primarily due to updated provider network records.

B. PROVIDER OPEN PANEL

This section addresses annual reporting requirements found in STC 24(e) and 40(b), regarding the number of network providers accepting new Demonstration populations. Supporting data is located in charts below. All MCOs submit monthly files to the enrollment broker identifying the number of PCPs and main dentists who are accepting new Medicaid patients, described here as "open panel" PCPs and "open practice" dentists. This section reports the open panel percentage for the overall provider network; section D of the report includes open panel data as a geoaccess measure. The state does not track the number of specialty providers accepting new patients, which is consistent with the Texas Department of Insurance's network review practices. To determine whether the plans have adequate specialist networks, HHSC monitors member and provider complaints and tracks total network participation, geomapping results, and out-of-network utilization. Other sections of this report discuss these monitoring results.

1. STAR and STAR+PLUS Statewide

Across the STAR program, open panel PCP rates reached 85 percent in SFQ2 and increased to 87 percent in SFQ4. Across the STAR+PLUS program in SFQ2, the open panel PCP rate reached 87 percent and increased to 91 percent in SFQ4.

2. STAR and STAR+PLUS by SDA

Throughout 2014 in the STAR program, a few SDAs maintained high open panel PCP rates, such as El Paso, Hidalgo, MRSAs Central, NE, and West, and Nueces. Open panel PCP rates fell a few percentage points short of the 80 percent benchmark in MRSA Central and Tarrant

SDAs due to low open panel rates with Amerigroup, Superior, and Cook health plans. Open panel PCP rates fell a few percentage points short of the 80 percent benchmark in Travis SDA due to low open panel rates with Amerigroup.

3. STAR and STAR+PLUS by MCO

Broken down by MCO, most open panel PCP rates remained relatively stable throughout 2014. MCO performance remained consistent across all quarters in 2014. Amerigroup STAR failed to meet the 80 percent benchmark in Dallas, MRSAs Central and West and Tarrant SDAs. Cook Children's STAR hovered around 62 percent throughout 2014. FirstCare STAR and Texas Children's STAR missed the open panel PCP benchmark of 80 percent by a few points throughout 2014. Superior STAR missed the 80 percent benchmark in Bexar, MRSA Central, and Travis SDAs throughout 2014. Amerigroup STAR+PLUS failed to meet the open panel PCP benchmark in Travis SDA throughout 2014 by 20 or more percentage points. Superior STAR+PLUS also failed to meet the benchmark in Bexar SDA by a few percentage points. The open panel PCP standard is a benchmark and the state routinely monitors additional measures discussed in this section of the report as indicators of network adequacy.

Even though the open panel rates for certain MCOs or SDAs do not meet the 80 percent benchmark, MCOs are required to assign 100 percent of non-dual members to a PCP within 5 business days of MCO enrollment. HHSC confirmed that all MCOs, including Amerigroup, Cook, and Texas Children's, assign members to a PCP and all PCPs have access to at least two age appropriate PCPs within established mileage standards.

Notable plans with open panel PCP rates at 95 percent or higher throughout 2014 included Christus STAR, Driscoll STAR, Scott & White STAR, Seton STAR and United STAR+PLUS.

4. Dental Program

Both dental plans met the state's 90 percent standard for main dentists with open practices in every fiscal quarter of 2014.

Open Panel PCP by MCO (2014 Q2-Q4)

Program	MCO	February 2014	May 2014	August 2014
STAR	Aetna	93%	93%	93%
	Amerigroup	78%	78%	82%
	BCBS	93%	92%	91%
	CHC	91%	91%	91%
	Christus	100%	100%	100%
	Community First	95%	95%	94%
	Cook	61%	62%	63%
	Driscoll	96%	97%	96%
	El Paso First	95%	94%	94%
	FirstCare	81%	80%	81%
	Molina	90%	91%	91%
	Parkland	87%	87%	92%
	Scott & White	98%	98%	98%
	Sendero	93%	92%	92%
	Seton	100%	100%	100%
	Superior	84%	85%	85%
	Texas Children's	79%	77%	77%
	United	94%	93%	93%
STAR Average		85%	85%	87%
STAR+PLUS	Amerigroup	81%	80%	85%
	Cigna-HealthSpring	93%	92%	92%
	Molina	90%	90%	90%
	Superior	90%	89%	97%
	United	94%	93%	95%
STAR+PLUS Average		87%	87%	91%

Open Panel PCP by SDA (2014 Q2-Q4)

Program	SDA	February 2014	May 2014	August 2014
STAR	Bexar	87%	87%	86%
	Dallas	83%	83%	87%
	El Paso	94%	95%	95%
	Harris	88%	87%	89%
	Hidalgo	97%	97%	97%
	Jefferson	88%	88%	89%
	Lubbock	84%	84%	84%
	MRSA Centra	76%	77%	78%
	MRSA NE	85%	85%	86%
	MRSA West	82%	82%	82%
	Nueces	96%	95%	96%
	Statew ide	85%	85%	87%
	Tarrant	80%	80%	83%
	Travis	88%	88%	89%
STAR+PLUS	Bexar	82%	81%	88%
	Dallas	88%	87%	94%
	El Paso	97%	96%	96%
	Harris	89%	89%	91%
	Hidalgo	98%	98%	98%
	Jefferson	89%	89%	91%
	Lubbock	89%	89%	91%
	MRSA Centra	NA	NA	96%
	MRSA NE	NA	NA	97%
	MRSA West	NA	NA	94%
	Nueces	95%	93%	98%
	Statew ide	87%	87%	91%
	Tarrant	81%	81%	84%
	Travis	63%	65%	72%

C. SERVICE UTILIZATION

Analysis of service utilization is based on the completed year SFY 2013 for acute care services and pharmacy services and based off encounter data. Due to lag times for providers to submit claims, the full picture of finalized encounter data is not yet available for SFY 2014. Long term services and supports are not included and expenditures represent the amount the MCO reimbursed the provider.

Depicted in the figures below, professional claims made up almost 40 percent of the total expenditures in STAR and STAR+PLUS in 2013. Inpatient" refers to inpatient hospital services and "outpatient" refers to services received at a hospital on an outpatient basis and at non-hospital facilities such as skilled nursing, intermediate care, home health agency, and various types of ambulatory clinics. Inpatient and outpatient combined, account for about one third of

expenditures. For inpatient, outpatient, pharmacy and dental claims, the STAR program spent more than STAR+PLUS while STAR+PLUS spent slightly more than STAR on professional claims.

Figure 7: Expenditures by Claim Type (2013)

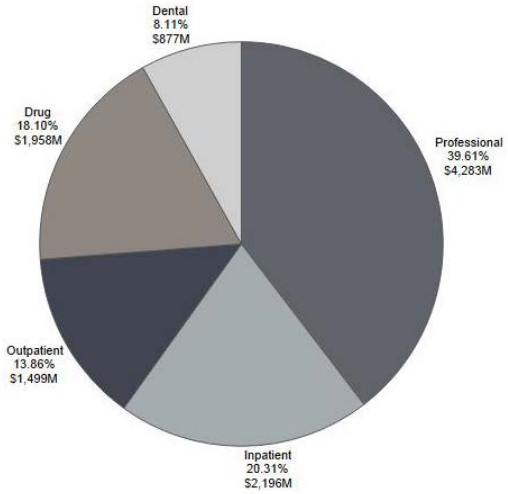
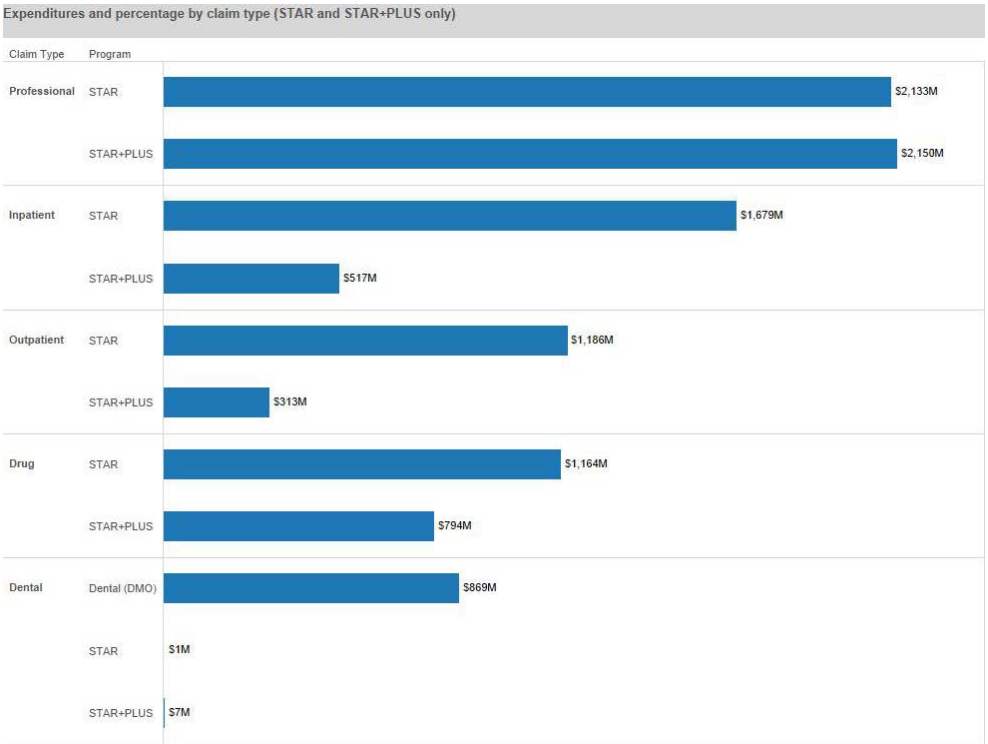
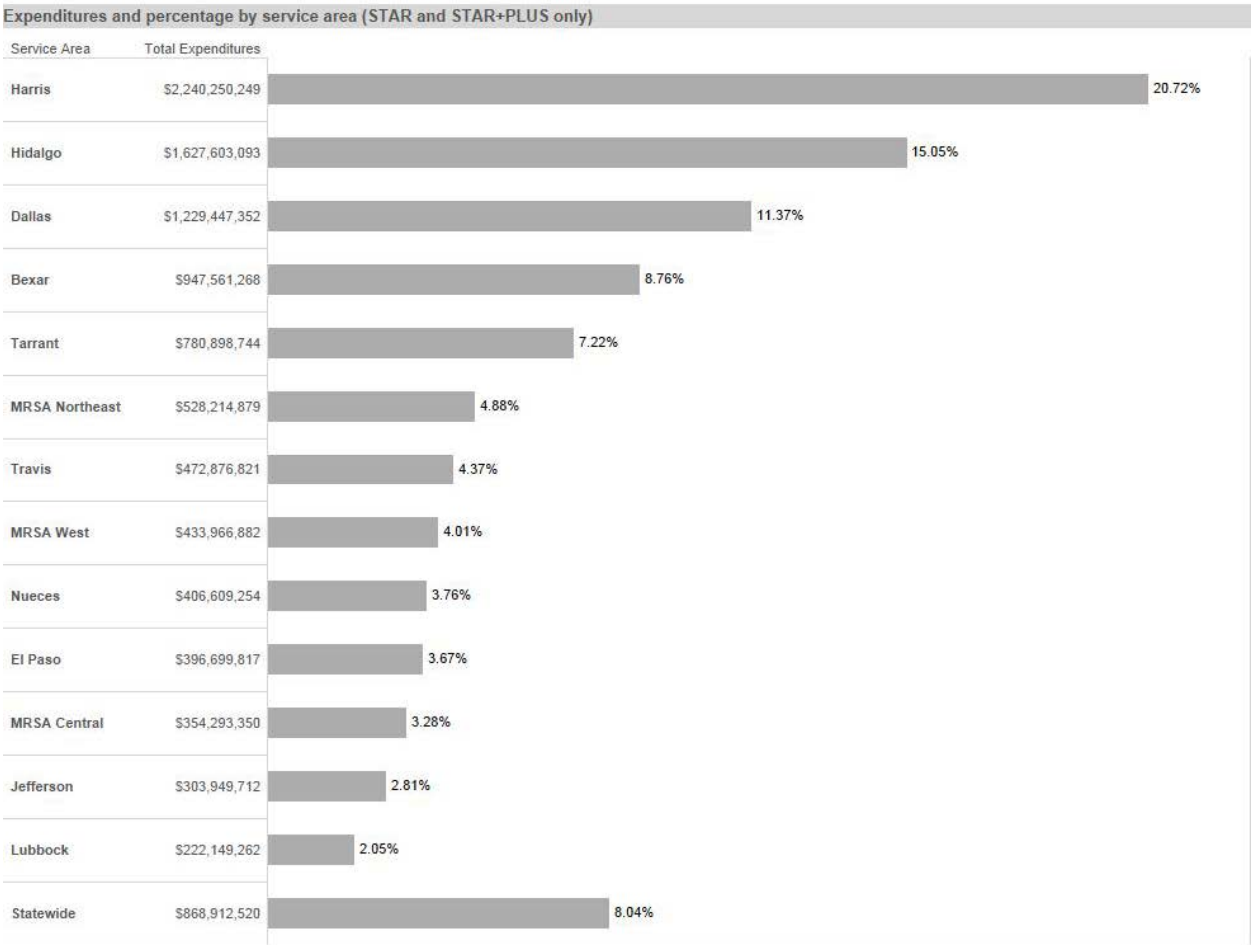


Figure 8: Expenditures by Program and Claim Type (2013)



In 2013, the percent of total expenditures by SDA mirrored the percentage of enrollment by SDA. The figure below shows percentage of expenditures by SDA. Compared to percentage of enrollment by SDA, expenditures mostly exceeded enrollment by one or two percent in Harris, Dallas, Tarrant, MRSA Northeast, El Paso, MRSA Central. None of the SDAs' expenditures significantly exceeded expectations based on enrollment in that SDA.

Figure 9: Expenditures by SDA (2013)



Compared to enrollment market share, expenditures as a percentage by MCO and program were also somewhat consistent, reflected in the figure below. In the STAR program, Superior, Community Health Choice, Molina, Cook, and Aetna's percentage of expenditures exceeded enrollment market share by 0.5 to approximately two percent. In the STAR+PLUS program, Superior expenditures as a percent of the total exceeded the enrollment market share by approximately 4.5 percent.

Figure 10: Expenditures and Enrollment by SDA (2013)

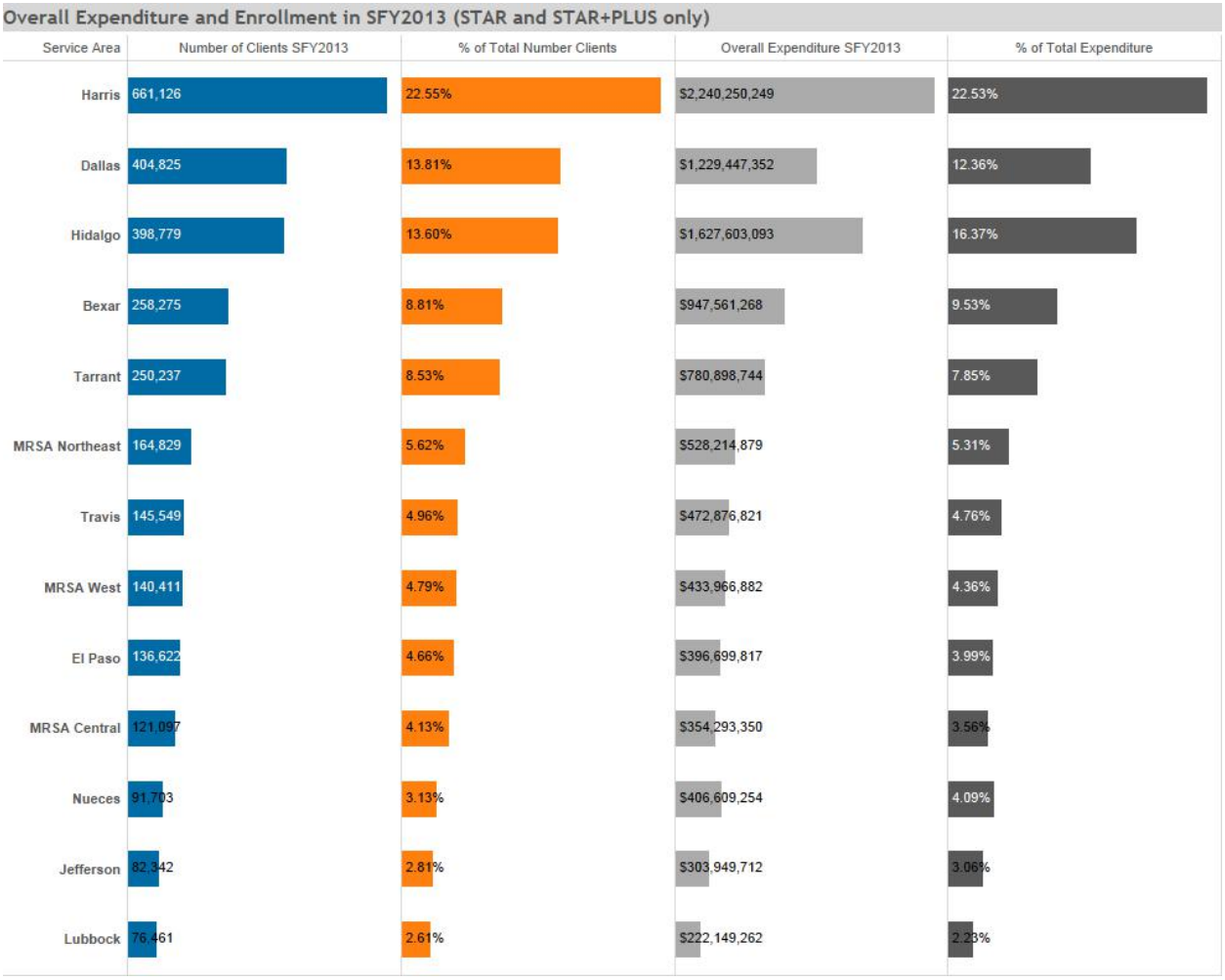


Figure 11: Expenditures by Program and MCO (2013)

Acute Care Services and Vendor Drug Expenditures for STAR and STAR+PLUS only, SFY2013

Dental (DMO)	DentaQuest - CMDS	$453,817,626	52.23%
	MCNA Dental - CMDS	$343,233,706	39.50%
	Delta Dental - CMDS	$71,861,187	8.27%
	Subtotal for Program	$868,912,520	
STAR	Superior Health Plan	$1,749,282,256	28.38%
	Amerigroup	$1,214,580,725	19.71%
	Texas Children's Health Plan	$548,121,934	8.89%
	Community Health Choice	$528,498,088	8.58%
	Parkland	$381,735,741	6.19%
	FirstCare	$262,884,639	4.27%
	Molina Healthcare of Texas	$225,642,392	3.95%
	United Healthcare	$243,390,318	3.66%
	Driscoll Children's	$219,441,965	3.56%
	Community First Health Plans	$180,405,102	2.93%
	Cook Children's Health Plan	$171,168,837	2.78%
	Aetna Medicaid	$160,773,475	2.61%
	El Paso First	$88,449,061	1.44%
	RightCare Scott and White He..	$85,815,082	1.39%
	Blue Cross & Blue Shields of ..	$33,837,963	0.55%
	Sendero Health Plans	$26,746,492	0.43%
	Seton Health Plans	$22,307,101	0.36%
	Christus Health Plan	$19,966,512	0.32%
	Subtotal for Program	$6,163,047,683	
STAR+PLUS	Superior Health Plan	$1,194,483,652	31.59%
	Amerigroup	$1,024,646,165	27.10%
	Molina Healthcare of Texas	$742,213,787	19.63%
	United Healthcare	$573,094,781	15.16%
	HealthSpring	$247,034,615	6.53%
	Subtotal for Program	$3,781,472,999	
Grand Total		$10,813,433,201	

D. GEOACCESS

The data below is based on plans' self-reported geomapping data as well as HHSC Strategic Decision Support (SDS) geomapping reports from 2014 SFQ4. Attachments E, G, and H show HHSC geomapping results by plan and SDA for the following provider types and populations:

- All STAR and STAR+PLUS members: open panel PCP; pharmacy
- Children STAR and STAR+PLUS: otolaryngologist (ENT)
- Children STAR: ENT; orthopedic surgeon; Obstetrician/Gynecologist
- Dental members: main dentists; endodontic; oral surgery; orthodontic; periodontist; prosthodontist

Attachments I, J, and K provide a summary of the plans' self-reported geomapping data by plan and SDA for several provider types. The requirements for provider types vary by program and population as described below.

- All STAR and STAR+PLUS members: open panel PCPs; obstetrician/gynecologist for female members; outpatient behavioral health services; acute care hospitals; pharmacy
- All STAR and children in STAR+PLUS: allergy/immunology; orthopedic surgery
- Children STAR and STAR+PLUS: ENT
- Adults STAR: cardiology; gastroenterology; nephrology; pulmonology
- Dental members: main dentists; endodontic; oral surgery; orthodontic; periodontist; prosthodontist

1. Member Access to PCPs, Specialists, and Hospitals

The 14SFQ4 results demonstrate that across the state, the STAR and STAR+PLUS programs exceeded the State's 90 percent benchmarks for most provider types. Both HHSC findings and MCO self-reported data demonstrate that all children and adults had access to an open panel PCP within 30 miles of their homes in both STAR and STAR+PLUS. Attachment E2 shows the geoaccess measures by MCO for five common provider specialties, including geoaccess maps, prepared semi-annually by HHSC.

In the STAR program, all MCOs met the geoaccess requirements in 2014 except for allergist/immunologist and ENT in MRSA West due to a provider shortage in that SDA. All MCOs in that SDA failed to meet the benchmark for percent of child or adult members residing within 75 miles of one allergist/immunologist. Almost all MCOs met all standards for all provider types in the STAR+PLUS program. United STAR+PLUS failed to meet the access standard for acute care hospitals in Nueces SDA. All children and adults in STAR and STAR+PLUS had access to an open panel PCP within the mileage standard.

The majority of STAR and STAR+PLUS PCP and specialty provider mileage requirements were met in 2014. HHSC continues to monitor other indicators of network adequacy, also discussed in this section of the report.

2. Pharmacy GeoMapping

Attachments G and J provide summaries of HHSC and MCO self-reported geomapping data by plan and SDA for pharmacies. For all STAR and STAR+PLUS service areas, the following benchmarks applied:

- 80 percent – in urban counties, access to a network pharmacy within 2 miles (75 percent in MRSAs)

- 75 percent – in suburban counties, access to a network pharmacy within 5 miles (55 percent in MRSAs)
- 90 percent – in rural counties, access to network pharmacy within 15 miles
- 90 percent – pharmacy in all counties, access to a 24-hour within 75 miles (only available on MCO self-reported data)

Certain areas continued to have deficiencies in meeting access standards in SFQ4. The greatest shortfalls are suburban pharmacies in MRSA Northeast and West. While there are shortfalls in the mileage standard, HHSC only received one member complaint regarding pharmacy in MRSA West and one in MRSA Northeast. Neither complaint was related to access to pharmacies. One complaint concerned eligibility and the second concerned the quantity of prescriptions that could be filled while the member was on fee for service. It is important to note that 100% of members have access to mail order pharmacies. This is a particularly important accessibility benefit for members who require maintenance medications to manage chronic health conditions. It is also a benefit for members who lack access to transportation.

3. Dental GeoMapping

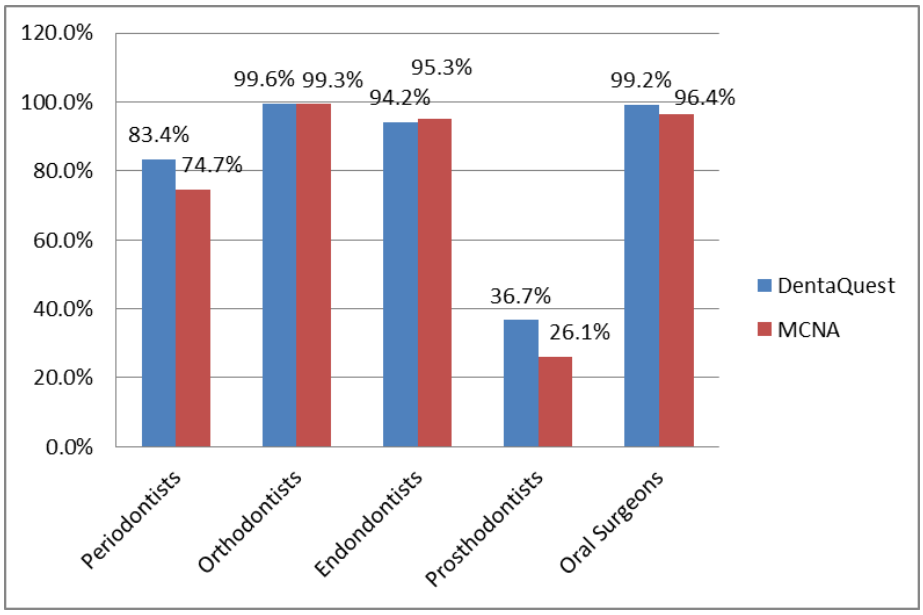
Dental geomapping results are divided into eleven Texas regions. Within each region, HHSC generates a report on the percentage of members in urban and rural areas with access to main dentists, endodontists, oral surgeons, orthodontists, periodontists, and prosthodontists. Attachments H and K provide summaries of HHSC and dental maintenance organizations (DMOs) self-reported geomapping information for both dental plans.

The dental contracts require plans to provide access to at least two providers within the benchmarks and travel distances:

- 100 percent – in urban areas, open practice main dentist within 30 miles
- 100 percent – in rural areas, open practice main dentist within 75 miles
- 95 percent – in urban and rural areas, specialists within 75 miles

In SFQ4, both DentaQuest and MCNA maintained mostly sufficient provider networks for main dentists in rural and urban counties as well as pediatric dentists statewide. Access to dental specialty providers is limited in some parts of Texas, as depicted in the figure below. This is, in part, due to overall provider shortages in these areas. Both DMOs report continuing activities to monitor the State Licensing Board website, HHSC claims administrator website, and utilize other internet resources in an effort to identify potential recruitment opportunities.

Figure 12: Percent of Dental Program Members with Access to Two Providers (2014 Q4)



E. PROVIDER 24/7 AVAILABILITY

After-hours access is especially important on a recurring basis for access to PCPs, 24 hour pharmacies, emergency hospital care, and behavioral health services. This section fulfills the annual reporting requirement of STC 39(c), MCO compliance with access to providers 24 hours a day, 7 days a week (24/7). The managed care contracts outline accessibility and availability requirements, including access to emergency and behavioral health services; access to PCPs 24 hours a day, 7 days a week; and appointment availability and wait times.

According to the managed care contracts, MCOs must ensure compliance with provider 24/7 accessibility through their provider networks. HHSC recently requested the results of each MCO's efforts to systematically evaluate continuous access to PCPs in 2014.[1]

[1] Uniform Managed Care Terms and Conditions (UMCC) 8.1.3 and 8.1.4
See also Title 28 of the Insurance code, Rule 11.1607 that PCPs be available and accessible 24 hours per day, seven days per week within an HMO's service area.

1. General Emergency Services

According to the managed care contracts, emergency services must be provided to members without regard to prior authorization or the provider's contractual relationship to the MCO, and general patterns of access are addressed in the out-of-network section of this report.

If medically necessary covered services are not available through network providers, the MCO must, upon the request of a network provider, allow a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation.

2. Pharmacy

According to the managed care contracts, MCOs must guarantee access to at least one 24-hour pharmacy within 75 miles for adult and children members. In 2014 SFQ4, most MCOs in most SDAs met the geoaccess standard in STAR and STAR+PLUS (see Attachment J). Two SDAs have a shortage of pharmacy providers and as a result, MCOs were less likely to meet the access standard in Hidalgo and MRSA West SDAs.

3. Behavioral Health

According to the managed care contracts, the MCOs must have a toll-free hotline to handle routine, emergency, and crisis behavioral health calls. The hotline must be available 24 hours a day, 7 days a week. MCOs are required to meet and report hotline performance standards to HHSC each quarter (see Attachment M). In 2014, all MCOs met the standards related to the behavioral health hotline.

4. Twenty-four Hour PCP Access

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

Each MCO is also required to systematically and regularly verify that covered services furnished by PCPs meet the 24/7 access criteria and enforce access standards where the providers are non-compliant.

In 2014, MCOs conducted after-hour surveys of network providers and confirmed the following percent of PCPs met the accessibility standards required by managed care contracts. Compliance ranged between 38 and 99 percent. Seven MCOs did not have survey data for 2014; HHSC will require each MCO out of compliance to submit a proposed corrective action plan subject to approval by HHSC.

2014 MCO	PCP After Hours Telephone Availability
Amerigroup	38.0%
Aetna	no data in 2014
BCBS	66.5%
Christus	no data in 2014
Cigna-HealthSpring	88.0%
Community 1st	97.5%
Community Health Choice	61.0%
Cook	no data in 2014
Driscoll	no data in 2014
El Paso 1st	62.7%
FirstCare	46.8%
Molina	77.0%
Parkland	no data in 2014
Scott & White	99.0%
Sendero	96.0%
Seton	not monitored in 2014
Superior	56.5%
Texas Children's	95.5%
United	no data in 2014

5. Appointment Availability

According to the managed care contracts, the MCO must ensure waiting times for appointments do not exceed 14 days for routine primary care and 24 hours for urgent care. MCOs provided the following accessibility data for 2014 based on monitoring of appointment availability and wait times. Compliance results ranged between 36 and 100 percent for routine care and between 82 and 100 percent for urgent care. Three MCOs did not have survey data from 2014; HHSC will require each MCO out of compliance to submit a proposed corrective action plan subject to approval by HHSC.

2014 Appointment Availability		
MCO	Routine Primary Care	Urgent Care
Amerigroup	98.0%	83.0%
Aetna	47.0%	96.0%
BCBS	no data in 2014	no data in 2014
Christus	36.0%	98.6%
Cigna-HealthSpring	92.5%	81.5%
Community 1st	no data in 2014	no data in 2014
Community Health Choice	~~80~~97.0%	95.0%
Cook	100.0%	NA
Driscoll	97.0%	93.0%
El Paso 1st	99.3%	
FirstCare	98.6%	NA
Molina	98.5%	97.3%
Parkland	40.3%	95.0%
Scott & White	95.9%	97.7%
Sendero	91.0%	95.0%
Seton	not monitored in 2014	not monitored in 2014
Superior	100.0%	100.0%
Texas Children's	99.5%	96.6%
United	77.0%	98.0%

6. EQRO Member Satisfaction Surveys

The External Quality Review Organization (EQRO) for Texas Medicaid conducts surveys related to member satisfaction with timeliness of care and access to primary and specialist care. The EQRO Summary of Activities (Attachment T4 of this report) summarizes the evaluation of activities conducted by the Institute for Child Health Policy at the University of Florida, which serves as the EQRO for Texas. The findings in this report are based on telephone surveys conducted with adult members and parents of child members of Medicaid members during fiscal years 2012 and 2013. Detailed survey results and analysis are contained in Attachment T4 on pages 86 through 94.

EQRO member satisfaction survey results are grouped by managed care program and not presented at the MCO-level. The table below is compiled based on the indicators of timeliness of care reported in Attachment T4.

Program	Good Access to Routine Care	Good Access to Urgent Care

STAR Adults	67%	74%
STAR+PLUS Adults	73%	77%
STAR Children	87%	91%

F. OUT-OF NETWORK UTILIZATION

As required by Texas law,[2] the State monitors health and dental plans' use of OON facilities and providers.[3] In each service area, OON utilization should not exceed the following thresholds:

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

1. SFQ4 of 2014

Attachment D1 provides a table with OON utilization rates by program, plan, and service area. The figure below shows average OON utilization rates by program and SDA.

Within the STAR program in 2014 SFQ4, OON utilization was generally higher in the Bexar, Dallas, and Harris SDAs. Within the STAR+PLUS program, OON was also higher in Dallas and Harris SDAs. This trend is due to strained contract negotiations between hospitals and MCOs. HHSC approved special consideration requests from the above and none will be subject to remedy. The State will continue to monitor these plans, and will require corrective action or other remedies if appropriate. The figure below shows OON utilization rates by health plan.

[2] Texas Government Code §533.005(a)(11).
[3] 1 Texas Administrative Code §353.4(e)(2).

Figure 13: Out-of-network Averages STAR [ems1](2014 Q4)

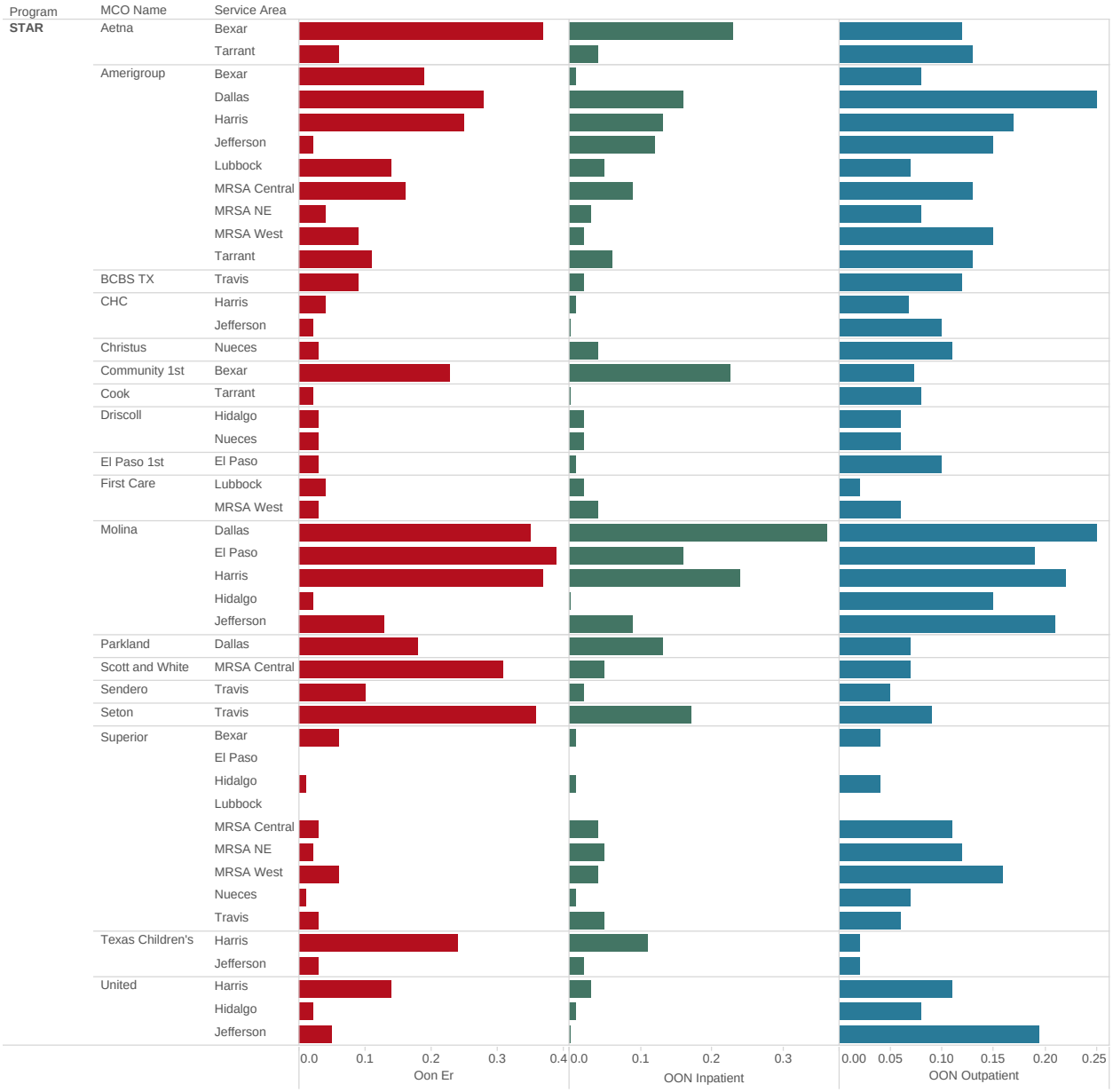
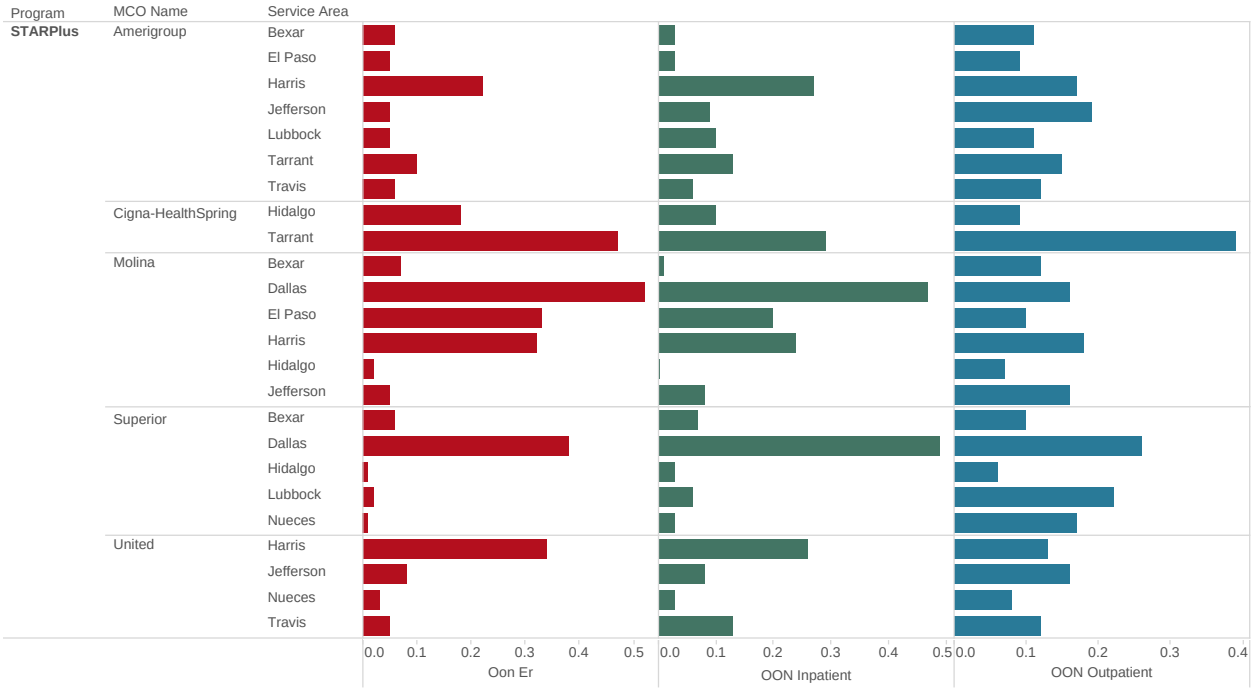


Figure 14: Out-of-network Averages STAR+PLUS [ems2](2014 Q4)



Under certain circumstances, plans may request time-limited exemptions from the OON standards if the plans provide evidence warranting special consideration. In order to be granted an exemption the plan must demonstrate both that admissions or visits to a single OON facility account for 25% or more of the Plan's admissions or visits in a reporting period; and the plan can demonstrate that it made good faith reasonable efforts to contract with an OON facility to no avail. If the state grants the special consideration, it removes the non-contracted provider from the plan's compliance calculations. Plans that do not exceed out of network utilization thresholds with approved special considerations are not be subject to remedies or assessed liquidated damages (LDs). The graph below depicts the recalculated OON rates averaged by health plan.

Figure 15: Recalculated Out-of-network Averages STAR [ems3](2014 Q4)

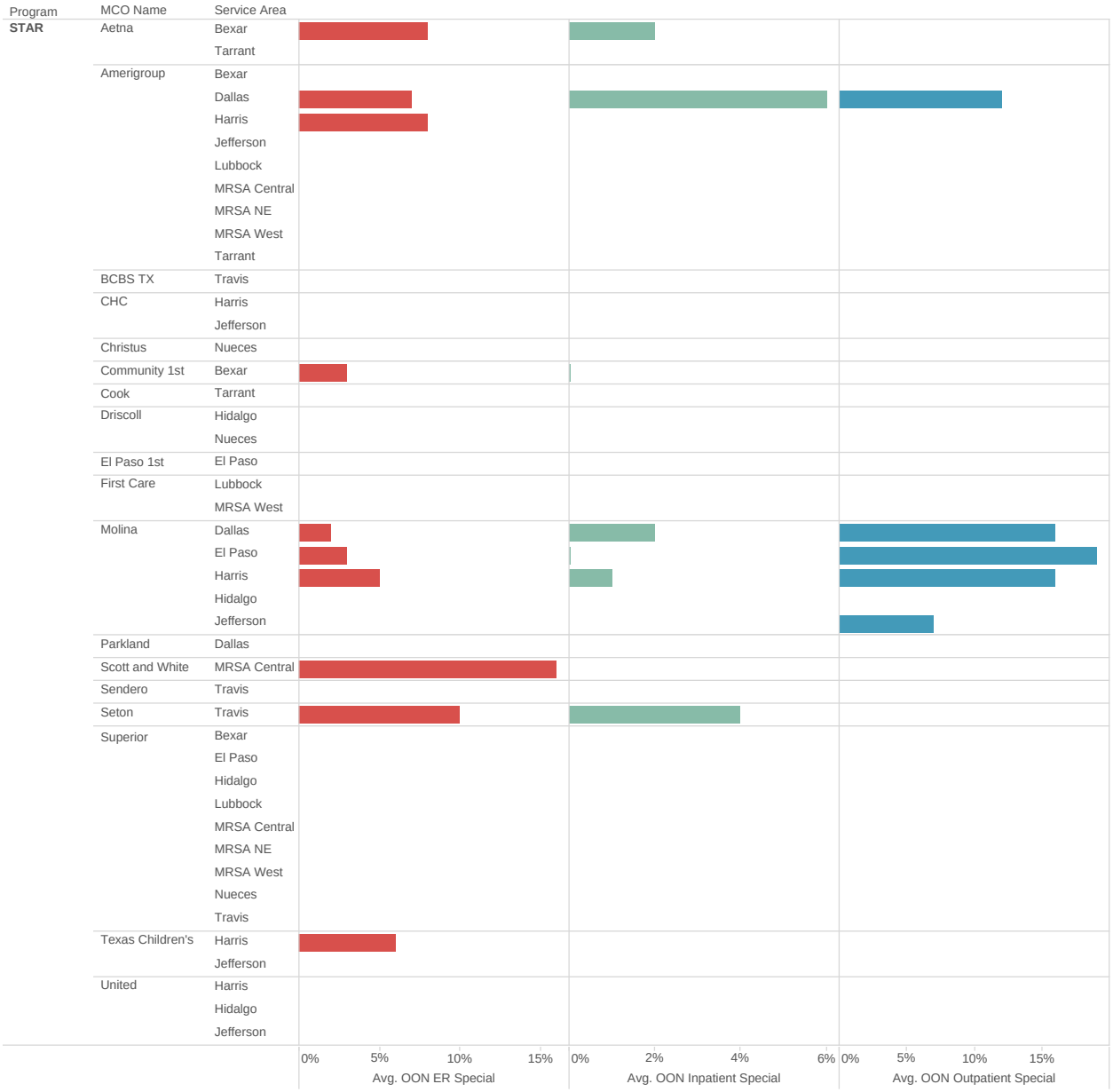
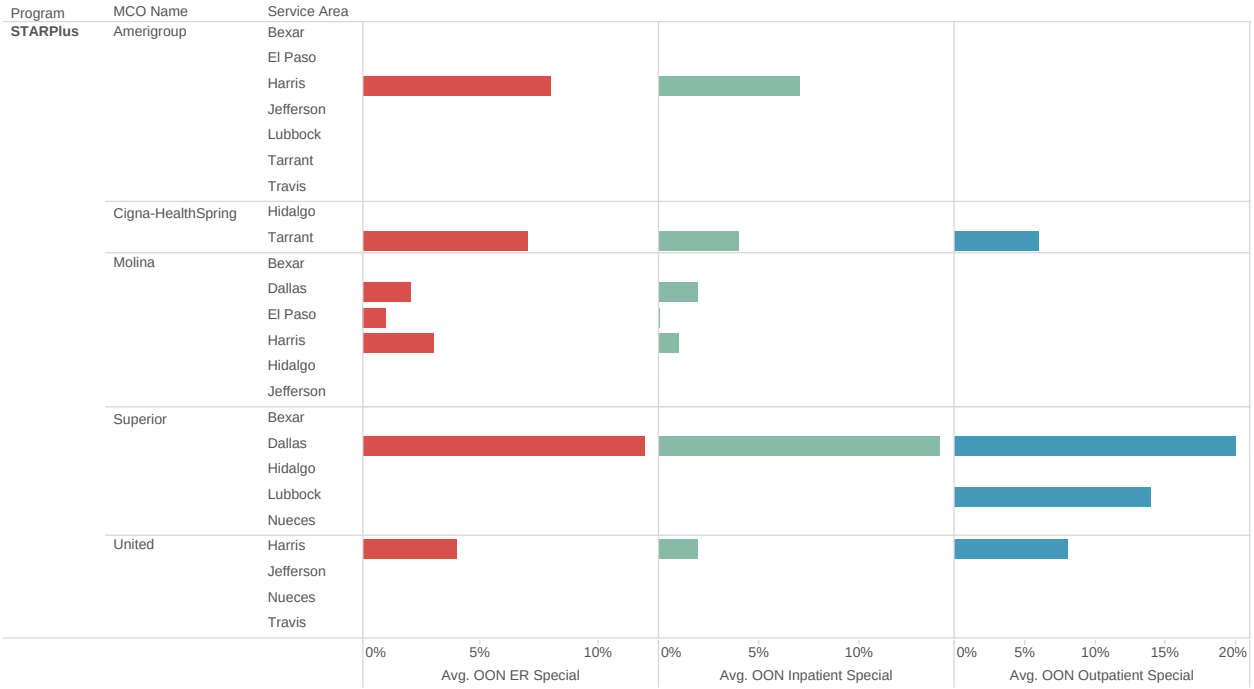


Figure 16: Recalculated Out-of-network Averages STAR+PLUS [ems4](2014 Q4)



1. SFQ1 through SFQ4 of 2014

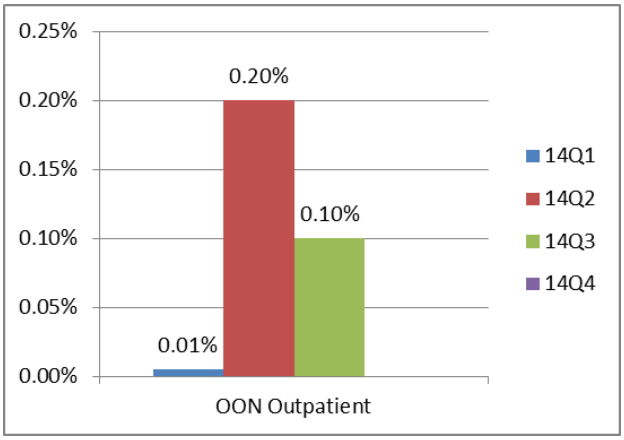
Throughout 2014, the average ER and inpatient OON usage decreased slightly while outpatient OON usage remained the same. The figure below depicts the average OON utilization for the STAR program, aggregated by MCO and service area. In the STAR+PLUS program, as the figure below shows, average ER and inpatient OON usage decreased while outpatient OON increased slightly in 2014. The following plans exceeded OON utilization standards in all four quarters of 2014:

- Aetna STAR in Bexar SDA
- Amerigroup STAR in Dallas and Harris SDAs
- Community First STAR in Bexar SDA
- Molina STAR in Dallas, El Paso, and Harris SDAs
- Scott & White STAR in MRSA Central
- Texas Children's STAR in Harris SDA
- Amerigroup STAR+PLUS in Harris SDA
- Cigna-HealthSpring STAR+PLUS in Tarrant SDA
- Molina STAR+PLUS in El Paso and Harris SDAs
- Superior STAR+PLUS in Dallas SDA
- United STAR+PLUS in Harris SDA

Attachment D2 also shows a more detailed depiction of OON utilization rates for ER, inpatient, and other services by program, SDA, and MCO throughout all four quarters in 2014.

Dental plans continued to report out-of-network utilization well below the 20 percent threshold at less than 0.5 percent, as shown in the figure below. In the Dental Program, the 20 percent standard for "other services" applies to out-of-network dental services.

Figure 17: Average Dental Program Out-of-Network Utilization (2014)



III. OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

This section addresses the quarterly requirements for STC 65 regarding outreach and other initiatives to ensure access to care. The Dental Stakeholder Update addresses STC 40(c), the Medicaid Managed Care Advisory Committee meeting update also addresses STC 65.

A. ENROLLMENT BROKER AND PLAN ACTIVITIES

The state's enrollment broker, MAXIMUS, performs various outreach efforts to educate potential clients about their medical and dental enrollment options. During the 2014 D3 Demonstration period (July - September 2014), MAXIMUS sent 402,616 enrollment mailings to potential STAR and STAR+PLUS clients, and 269,973 mailings to potential dental program clients. MAXIMUS field staff completed 32,595 home visit attempts for these programs, and 255,512 phone call attempts. Additionally, MAXIMUS completed 5,602 field events, which include enrollment events, community contacts, presentations, and health fairs. The full report is available in Attachment L.

The state's managed care contracts also require health and dental plans to conduct provider outreach efforts and educate providers about managed care requirements. Plans must conduct

training within 30 days of placing a newly contracted provider on active status. Training topics that promote access to care include:

- covered services and the provider's responsibility for care coordination;
- the plan's policies regarding network and OON referrals;
- Texas Health Steps benefits; and
- the State's Medical Transportation Program.

To promote access to care, health and dental plans must update their provider directories on a quarterly basis, and online provider directories are updated by MCOs at least twice a month. Plans also must mail member handbooks to new members no later than five days after receiving the state's enrollment file, and to all members at least annually and upon request. The handbooks must describe how to access primary and specialty care.

Through the member handbooks and other educational initiatives, plans must instruct members on topics such as:

- how managed care operates, and the role of the primary care provider or main dentist;
- how to obtain covered services;
- the value of screening and preventative care; and
- how to obtain transportation through the State's Medical Transportation Program.

B. DENTAL STAKEHOLDER MEETING

There was no dental stakeholder meeting this quarter. In addition, there were no changes to the Texas Health Steps dental checkup elements this quarter. HHSC is evaluating options for ongoing communication with dental stakeholders. HHSC staff continues to answer questions submitted to the state's dental stakeholder email box: DentalStakeholderMeeting@hhsc.state.tx.us.

C. MEDICAID MANAGED CARE ADVISORY COMMITTEE

The State Medicaid Managed Care Advisory Committee (SMMC) serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care. The link to the SMMC web page, which lists the members and affiliations, is located here: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/smmcac.shtml

The SMMC held one meeting in SFQ4 on July 18, 2014. At that meeting the committee heard from the state enrollment broker, MAXIMUS. It also received an update on other advisory committee activities, an update from the network advisory work group, and updates on various managed care initiatives. The committee sent 48 draft recommendations and requested feedback

from HHSC staff. The committee will consider the comments from HHSC staff as well as stakeholder input at the next meeting in Austin on October 21, 2014. The committee will vote on those recommendations which may require legislative action in order to implement.

D. PUBLIC FORUM

In accordance with STC 14, Post Award Forum, HHSC afforded the public with an opportunity to provide comment on the progress of the Demonstration at the quarterly HHSC Stakeholder Forum, held on July 14, 2014. The date, time and location of the Stakeholder Forum were published on the HHSC website at least 30 days prior to the date of the forum. The HHSC Stakeholder Forum is open to the public. HHSC staff presented an overview of progress to date on the demonstration waiver and took questions and feedback from those in attendance. An archived recording of the forum is posted on the HHSC website.

E. INDEPENDENT CONSUMER SUPPORTS SYSTEM PLAN

HHSC submitted a plan to CMS on May 1, 2014, describing the structure and operation of the Independent Consumer Supports System that aligns with the core elements provided in STC 20. The Texas Independent Consumer Support System consists of the HHSC Medicaid/CHIP Division, the Office of the Ombudsman, the State managed Enrollment Broker (EB, MAXIMUS), and community support from the Aging and Disability Resource Centers (ADRCs). Once the plan is approved, HHSC will provide progress updates on its activities.

F. HHSC MANAGED CARE INITIATIVES

Individuals newly eligible for STAR+PLUS starting September 1, 2014 began receiving enrollment packets in June 2014. The enrollment period ended August 15, 2014 and any mandatory candidate who had not selected a health plan was defaulted into a plan by HHSC. Choice and default enrollment rates were reported in section II of this report. Nursing facility residents began receiving enrollment packets in November 2014 and will need to select a health plan by mid-February 2015 or the state will default them to a plan for the March 1, 2015 nursing facility carve-in. The Enrollment Broker is holding enrollment events in nursing facilities across the state November 2014 – February 2015.

HHSC representatives traveled extensively across the state to meet with providers and provider associations, as well as client's family members, advocacy organizations, and community groups to present on managed care and the upcoming initiatives. HHSC hosted statewide informational sessions from June through September 2014 for providers and client affected by the STAR+PLUS expansion. HHSC is hosting additional provider trainings across the state January through February 2015 for providers affected by the nursing facility transition to managed care.

In addition, HHSC facilitated face to face meetings between providers and STAR and STAR+PLUS health plans, in advance of the carve-in of mental health targeted case management benefits. Meetings were held in Round Rock, Harlingen, Tyler, Lubbock, Fort Worth and Lubbock. MCO representatives are on hand at all of these meetings to present and to answer questions.

For more information on all upcoming managed care initiatives, please visit the Expansion of Medicaid Managed Care webpage on the HHSC website:
http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-expansion/

IV. COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

The State manages enrollment in a 24-month window that includes one prospective month and 23 prior period adjustment months. During successive processing cycles, this allows the State to verify prior enrollments and implement adjustments to enrollments as necessary. The types of adjustments include revisions for newborns, deaths, change of service areas, and the addition of Medicare eligibility or eligibility attributes.

The State continues to conduct the quarterly MCO encounter financial reconciliation process for 2014 SFQ4. The State will contact each plan that did not achieve the financial reconciliation threshold, and advise them of the necessary steps to achieve contract compliance and, ultimately, certification.

V. OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENTS/ISSUES

This section addresses STC 65, regarding operational issues identified during the quarter. It also addresses pending lawsuits that may potentially impact the Demonstration, and new issues identified during the reported quarter.

A. UPDATE FROM PRIOR QUARTER

HHSC continues to investigate the issues identified in the annual report pertaining to the reporting of members with special health care needs (MSHCN). Preliminary analysis suggests that MCOs are not consistently identifying members for the MAXIMUS file based on HHSC guidelines. HHSC will continue to work with MAXIMUS and MCOs to better identify these members.

Approximately 100,000 people were enrolled in STAR+PLUS in the MRSAs as a result of the expansion and IDD carve-in on September 1, 2014. Approximately 800 manual enrollments were coordinated between Office of Social Services (OSS), DADS and HHSC to ensure access to care

for individuals transferring from the DADS Community Based Alternatives waiver to the Home and Community Based Services (HCBS) STAR+PLUS Waiver. As a result, MAXIMUS sent letters to these members in September to advise them about switching MCO enrollment. In addition, DADS sent a provider alert and HHSC posted information to the managed care expansion website to inform stakeholders of this action.

In the first week of the STAR+PLUS September 1, 2014 expansion, almost 200 individuals were defaulted to an MCO despite having made a choice. HHSC identified and corrected the cases and worked with the enrollment broker to contact the affected individuals or their authorized representatives to explain the resolution. The member's selected MCO was notified of the enrollment and was prepared to pay claims for services delivered starting September 1st. Providers were also notified and encouraged to verify an individual's eligibility for payment by using TMHP or the MCO's portal.

HHSC has not identified any other ongoing issues in the relevant subject matter sections of this report.

B. LITIGATION UPDATE

Below is a summary of pending litigation and the status. HHSC Legal is unaware of any threatened litigation affecting healthcare delivery.

Dr. Essa Kawaja, DDS; Summit Dental Center, Dental Smiles; Dr. Anila Shah, DDS, PA. v. HHSC, Suehs, Delta Dental, Dentaquest USA, and Managed Care of North America. Filed on February 28, 2012, in state district court in Travis County. Dental providers complained of the default enrollment procedures for Medicaid managed care clients that do not choose a provider. They asked the court to restrain HHSC and the Medicaid dental maintenance organizations from implementing the default enrollment procedures and to declare those procedures illegal. HHSC voluntarily delayed the dental home requirement until May 31, 2012, to allow clients more time to notify their dental plan of their preferred dentist without any disruption in service. Plaintiffs withdrew their request for a TRO following HHSC's action. OAG has filed a general denial and a plea to the jurisdiction. The case remains dormant since June 2012, but pending. Of all the lawsuits filed in 2011-2012 challenging HHSC's expansion of the Medicaid managed care delivery model, *Kawaja* is the sole case still pending. All others have been dismissed or resolved.

C. NEW ISSUES

HHSC has not identified any new issues in the relevant subject matter sections of this report, other than those already reported in previous sections. There were no issues outside of the general categories typically reported and HHSC does not anticipate any significant issues or activities in the near future that affect healthcare delivery.

D. BIANNUAL CLAIMS SUMMARY

This section addresses the requirements of STC 39(b) for biannual claims summary reporting, including the timeliness and accuracy of claims processing, and possible fraud and abuse detected.

1. Claims Adjudication

HHSC's managed care contracts include the following claims adjudication standards for clean claims:

- 98 percent must be adjudicated within 30 days;
- 98 percent of appealed claims must be adjudicated within 30 days; and
- 99 percent must be adjudicated within 90 days.

Attachment P is a summary of the health and dental plans' 2014 SFQ3 and SFQ4 claims adjudication results. For these quarters, STAR and STAR+PLUS MCOs reported results for acute care, behavioral health, vision services, and pharmacy claims. STAR+PLUS MCOs also reported results for long-term care claims. Dental plans reported results for all dental claims. The following plans did not meet the claims processing standards in 2014 SFQ3 and SFQ4:

- Amerigroup STAR in MRSA Central did not meet the standard for processing acute care claims due to incorrect provider information entered in the claims payment system. The plan corrected the information and reprocessed and paid claims with interest.
- Community Health Choice STAR in Harris SDA did not meet processing standards for clean acute care claims within 30 days.
- Molina STAR in Dallas, El Paso, Harris, Hidalgo, and Jefferson SDAs did not meet processing standards for acute, behavioral health, and vision claims. The plan was placed on CAP through 2014 and is not subject to LD at this time. Molina completed a special project for appealed claims on April 30, 2014.
- Scott and White STAR in MRSA Central did not meet processing standards for acute and behavioral health claims.

- Sendero STAR in Travis SDA did not meet processing standards for acute claims. The plan educated and trained its staff and increased frequency of internal monitoring from monthly to weekly to ensure processes are followed correctly.
- Superior STAR in Bexar, El Paso, Hidalgo, Lubbock, MRSA Northeast, MRSA Central MRSA West, Nueces, and Travis SDAs did not meet the processing standards for acute and behavioral health claims due to a routing error that resulted in delayed processing; Superior corrected the issue.
- United STAR in Harris SDA did not meet processing standards for behavioral health claims.
- Amerigroup STAR+PLUS in Bexar and El Paso SDAs did not meet the standard for processing appealed behavioral health claims.
- Cigna HealthSpring STAR+PLUS in Hidalgo and Tarrant SDAs did not meet standards for processing acute, behavioral health, vision, and long term services claims. The plan stopped processing claims in order to review and correct provider contracts. The plan completed the provider review, processed claims, and paid interest.
- Molina STAR+PLUS in Bexar, Dallas, El Paso, Harris, and Hidalgo SDAs did not meet standards for processing acute, behavioral health, vision, and long term services and supports claims. Molina completed a special project for appealed claims on April 30, 2014; HHSC implemented a CAP and the plan.
- Superior STAR+PLUS in Bexar, Dallas, Hidalgo, Lubbock, Nueces SDA did not meet standards for processing acute and long term services and supports claims due to a routing error that resulted in delayed processing; Superior corrected the issue.
- United STAR+PLUS in Harris SDA did not meet standards for processing acute, behavioral health, vision, and long term services and supports claims.

HHSC staff is in the process of developing an appropriate remedy for the issues reported above.

Both dental plans met the claim adjudication standards for clean claims in 2014 SFQ3 and SFQ4,

2. Provider Fraud and Abuse

The state's managed care contracts require health and dental plans to form special investigative units that refer suspected cases of fraud, waste, or abuse to the HHSC Office of Inspector General (OIG). Attachment R is a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period, 2014 SFQ3 and SDQ4.

In SFQ3 and SFQ4, health plans forwarded 49 suspected cases of fraud, waste, or abuse to the OIG. A majority of these referrals related to program non-compliance and non-appropriate billing. OIG returned about one third of the cases received to the MCO for the determination of appropriate action (15 referrals) and launched a full scale investigation for the second third (13

referrals). Dental plans forwarded 26 suspected cases of fraud, waste, or abuse to the OIG. Among the most common outcomes, most of the cases related to program non-compliance and inappropriate billing. OIG issued a full scale investigation or transferred information to existing full scale cases for 17 of the 26 cases.

VI. ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

This section describes the state's action plan for addressing issues identified in the quarterly report, as required by STC 65.

1. Managed Care Issues

Issues identified during the quarter have been addressed within the relevant subject matter sections of this report.

2. Litigation

Plans for addressing pending litigation are considered confidential client information, but HHSC will keep CMS informed of any significant court orders or decisions.

3. Other

There were no fiscal or systems issues, or legislative activity that occurred in 2014 SFQ4. The state does not anticipate any such activity in the near future that affects healthcare delivery.

VII. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

This section addresses the quarterly reporting requirements in STC 65, regarding financial and budget neutrality development and issues.

There were no significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality report for 2014 SFQ4.

VIII. MEMBER MONTH REPROTING

The tables below address the quarterly reporting requirements in STC regarding eligible member month participants, for the federal fiscal quarter four in 2014.

Eligibility Groups Used in Budget Neutrality Calculations (2014)

Eligibility Group	Month 1 (Jul 2014)	Month 2 (Aug 2014)	Month 3 (Sep 2014)	Total for Quarter Ending Sep 2014
Adults	287,185	290,024	293,119	870,328
Children	2,598,414	2,627,807	2,664,775	7,890,996
AMR	287,234	287,614	361,559	936,407
Disabled	427,517	427,091	427,907	1,282,515

Eligibility Groups Not Used in Budget Neutrality Calculations (2014)

Eligibility Group	Month 1 (Jul 2014)	Month 2 (Aug 2014)	Month 3 (Sep 2014)	Total for Quarter Ending Sep 2014
Adults in MRSA	75,975	76,177	-	152,152
Foster Care	33,504	33,683	33,814	101,001
Medically Needy	183	198	190	571
CHIP-Funded	137,929	161,784	185,828	485,541
Adoption Subsidy	42,838	43,050	43,263	129,151
STAR+PLUS 217- Like HCBS	13,778	13,998	16,703	44,480

IX. CONSUMER ISSUES

This section addresses quarterly reporting requirements in STC 39(a) regarding complaints and calls to HHSC Health Plan Management staff and the Office of the Ombudsman's Medicaid Managed Care Helpline (MMCH). It also includes trends discovered and steps taken to resolve complaints and prevent future occurrences.

The state tracks customer service issues, such as member and provider hotline performance, member complaints and appeals, and provider complaints through the managed care quarterly reports.

Attachments M, N, and O include supporting data for this section.

A. HOTLINE CALL VOLUME AND PERFORMANCE

This subsection includes quarterly data regarding call center volumes and plan performance. As addressed in prior quarterly reports, the state's health and dental plans consolidate all Medicaid and CHIP calls for reporting purposes.

Calls to the MCO Provider and Member hotlines increased by approximately four percent each in 2014 SFQ4, as shown in Attachment M. Between SFQ3 and 14SFQ4, calls to the member hotlines increased by 3.92 percent to 804,477. Total phone calls and calls to the provider hotlines increased by 4.25 percent to 587,887 phone calls. In the dental program, calls to the member and provider hotlines increased by 21 and 9 percent, respectively, in SFQ4.

The following graph shows the number of calls received to the member hotlines per 1000 members in quarters 2 through 4 of 2014. HHSC staff is looking into MCOs with higher than average hotline numbers.

Member Hotline Calls Received per 1000 Members (2014 Q2-Q4)

Member Hotline Calls per 1000 Members (2014)			
MCO	**Q2**	**Q3**	**Q4**
Aetna	524	510	483
Amerigroup	187	187	196
BCBS	282	290	273
CHC	182	192	201
Christus	315	315	301
Cigna-HealthSprin	761	920	1025
Community 1st	119	108	107
Cook Children's	229	203	176
DentaQuest	101	106	109
Driscoll	146	149	156
El Paso 1st	326	189	175
FirstCare	186	174	165
MCNA	133	141	140
Molina	317	317	314
Parkland	246	232	211
Scott & White	347	322	379
Sendero	325	239	282
Seton	407	397	466
Superior	240	230	227
Texas Children's	98	102	91
United	400	405	412
Statewide MCOs*	**230**	**225**	**224**
*does not include dental plans			

All MCOs and both DMOs met the following hotline performance in 2014 SFQ4:

- 99 percent of all calls must be answered by the fourth ring;
- ≤ 1 percent busy signal rate for all calls;
- 80 percent of all calls must be answered by a live person within 30 seconds;
- ≤ 7 percent call abandonment rate; and
- ≤ 2 minute average hold time.

B. COMPLAINTS AND APPEALS RECEIVED BY PLANS

Attachments N show the number of member complaints and appeals and provider complaints received by MCOs and DMOs.

1. STAR and STAR+PLUS

The total number of complaints and appeals received by plans decreased from 2014 SFQ3 to SFQ4, as shown in the figures below. STAR plans collectively reported 591 member complaints, 1,511 member appeals, and 268 provider complaints in SFQ4. STAR+PLUS plans received 882 member complaints, 1,014 member appeals, and 161 provider complaints in SFQ4. Amerigroup, Superior, United, and Molina make up more than 60 percent of STAR and STAR+PLUS member complaints. The STAR+PLUS MCOs receive significantly more member complaints and appeals per 1000 members than the STAR MCOs.

HHSC discovered an error with Community Health Choice (CHC) reporting from SFQ2 and SFQ4 in 2014. CHC acknowledged they had not counted and reported member appeals correctly and resubmitted reports to reflect an accurate count. HHSC will continue to monitor the volume and detail of member appeals to ensure accurate reporting. In addition, HHSC staff is in the process of developing an appropriate remedy

Figure 18: Complaints and Appeals Received by STAR MCOs (2014 Q2-Q4)

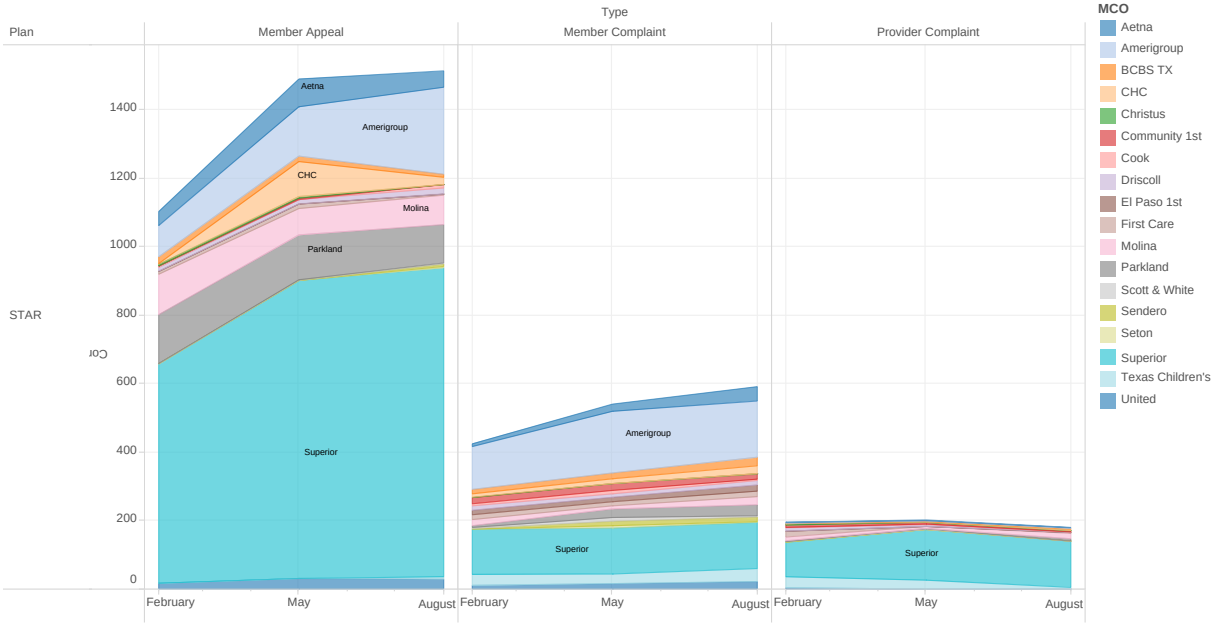


Figure 19: Complaints and Appeals Received by STAR+PLUS MCOs (2014 Q2-Q4)

The State's managed care contracts require the plans to track and monitor the number of complaints and appeals that are resolved within 30 days of receipt, and require 98 percent compliance with this benchmark. The following MCOs failed to meet the standard for percent of member complaints and appeals or provider complaints resolved within 30 days in SFQ4. HHSC staff is in the process of developing an appropriate remedy for the following MCOs:

- Community Health Choice STAR in Harris SDA failed to meet the standard for provider complaints but only received four complaints.
- FirstCare STAR in MRSA West SDA failed to meet the standard for member complaints.
- Texas Children's in Harris SDA failed to meet the standard for member complaints and member appeals.
- United STAR in Hidalgo SDA failed to meet the standard for member complaints and in Harris and Jefferson SDAs failed to meet the standard for member appeals.
- Amerigroup STAR+PLUS in Lubbock and Travis SDAs failed to meet the standard for member complaints and in Tarrant SDA failed to meet the standard for member appeals.
- Molina STAR+PLUS in Dallas SDA failed to meet the standard for provider complaints.
- United STAR+PLUS in Harris, Nueces, and Travis SDAs failed to meet the standard for member complaints and member appeals.

2. Dental Program

Between SFQ3 and SFQ4, dental member complaints increased by 20 percent, member appeals increased by 33 percent, and provider complaints decreased by 8 percent. The most common member complaint to the dental plans involved either dissatisfaction with the quality of care provided by a treating dental provider, or access to or availability of services. Member appeals primarily related to dental plans' utilization review or management, such as the denial of prior authorization requests. Providers generally complained about claims processing or plan administration.

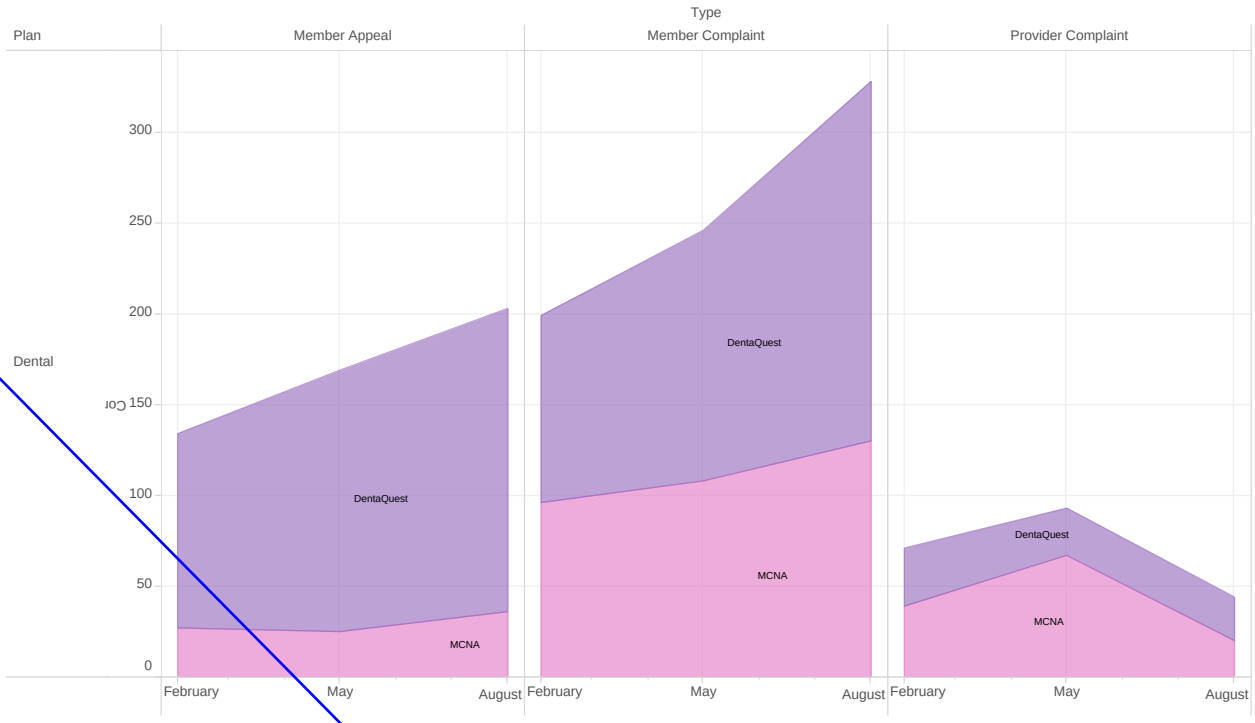
In the dental program in 2014, the total number of member appeals received increased by 250 percent, the total member complaints received increased by 13 percent, and the total provider complaints decreased by 23 percent. DentaQuest was responsible for the bulk of the increase in member appeals and complaints. Although DentaQuest holds roughly 55 percent of the member market share, the plan received 60 percent of the total dental member complaints and 82 percent of the member appeals in SFQ4.

DentaQuest's member complaints increased by 68 percent in 2014, characterized mostly by quality of care and accessibility and access to care issues. In addition, DentaQuest's member appeals increased by 391 percent in 2014 and the rate of overturned appeals increased from 42 percent in SFQ1 to almost 49 percent in SFQ4. The member complaints and appeals received by the DentaQuest in 2014 increased due to delayed enrollment data transmitted from HHSC to the DMO. In order to reduce errors, HHSC began providing the DMOs with weekly (rather than monthly) enrollment files in SFQ4. In addition, HHSC discovered two issues with DentaQuest staffing: first, DentaQuest needed to improve their system for processing enrollment files which the plan did; second, turnover in complaint management and staff led to delays and errors with processing complaints. DentaQuest hired two administrative coordinators to enter cases and determine the type of inquiry. HHSC will continue to investigate and monitor DentaQuest in subsequent quarters and is in the process of developing an appropriate remedy

Complaints and appeals are reported in aggregate for each statewide dental plan, so any fluctuations within service areas would not be captured by HHSC. Each health plan has over one million members enrolled across the state, therefore, the changes in complaints and appeals represent a very small fluctuation as a percentage of enrolled members that may be expected between fiscal quarters as utilization patterns change.

MCNA met or exceeded all performance standards for the timely resolution of complaints and appeals in SFQ3 and SFQ4. DentaQuest failed to meet the performance standard for percent of member complaints resolved within 30 days and is HHSC staff is in the process of developing an appropriate remedy.

Figure 20: Complaints and Appeals Received by DMOs (2014 Q2-Q4)



Program and Type	MCO Complaints and Appeals			Per 1000 Members		
	14Q2	14Q3	14Q4	14Q2	14Q3	14Q4
STAR						
Member Appeal	1,102	1,489	1,513	0.45	0.58	0.54
Member Complaint	424	540	591	0.17	0.21	0.21
STAR Total	**1,526**	**2,029**	**2,104**	**0.63**	**0.79**	**0.76**
STAR+PLUS						
Member Appeal	966	1,126	1,014	2.35	2.74	2.46
Member Complaint	786	936	882	1.92	2.28	2.14
STAR+PLUS Total	**1,752**	**2,062**	**1,896**	**4.27**	**5.02**	**4.60**
Appeal Statewide	**2,068**	**2,615**	**2,527**	**0.73**	**0.88**	**0.79**
Complaint Statewide	**1,210**	**1,476**	**1,473**	**0.43**	**0.50**	**0.46**
Dental						
Member Appeal	134	169	203	0.06	0.07	0.07
Member Complaint	199	246	328	0.08	0.10	0.12
Dental Total	**333**	**415**	**531**	**0.14**	**0.16**	**0.19**

C. COMPLAINTS RECEIVED BY THE STATE

In addition to monitoring complaints received by plans, HHSC also tracks the number and types of complaints submitted to the state. Members and providers can submit complaints to the HHSC Health Plan Management (HPM) team. Members can also call in to submit complaints through the Ombudsman's office via the MMCH. After investigating each complaint, state staff determines whether or not it is substantiated. A substantiated complaint is one in which research clearly indicates agency policy was violated or agency expectations were not met (.e.g. paying at an incorrect rate, member not receiving benefits).

1. STAR and STAR+PLUS

In the STAR program, the number of MMCH complaints and member complaints received by HPM increased by roughly 15 percent in 2014 SFQ4. In the STAR+PLUS program, the number of MMCH complaints and member complaints received by HPM decreased by roughly 15 percent in SFQ4. The most common member complaint issue type received by HPM in the STAR program was access to care and in the STAR+PLUS program it was access to care and benefit issues. The most common complaint issue type received by MMCH in the STAR program was prescription eligibility, billing problems, denial of authorization of care, and prescription private insurance. The most common complaint issue types received by MMCH in the STAR+PLUS program was access to long term care services, access to DME, care coordination, prescription eligibility, and denial of authorization of care.

Across STAR and STAR+PLUS, the number of provider complaints increased by 35 and 75 percent for each program in SFQ4. Over 60 percent of the types of provider complaints received had to do with denial of claims. Approximately 40 percent of provider complaints received by HPM and MMCH were substantiated in SFQ4.

Figure 21: Complaints to the State Regarding STAR (2014 Q1-Q4)

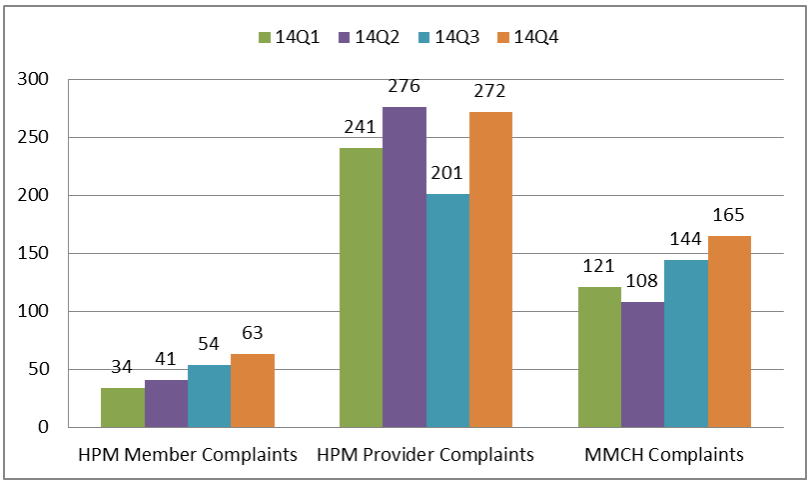
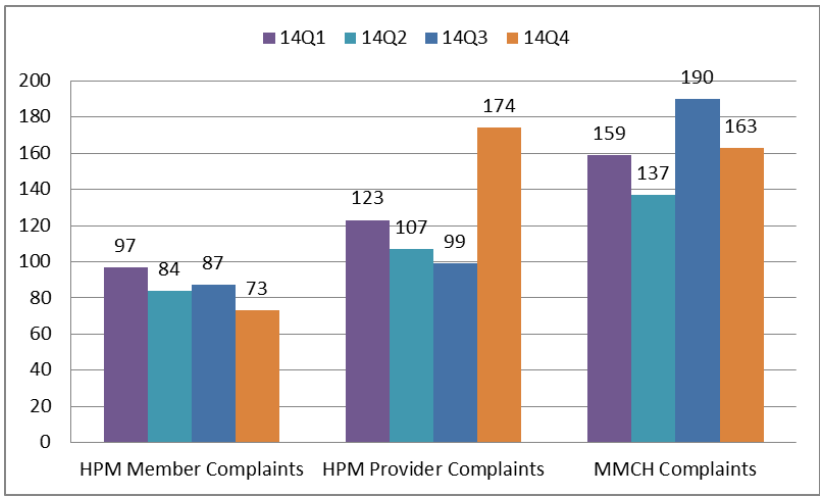
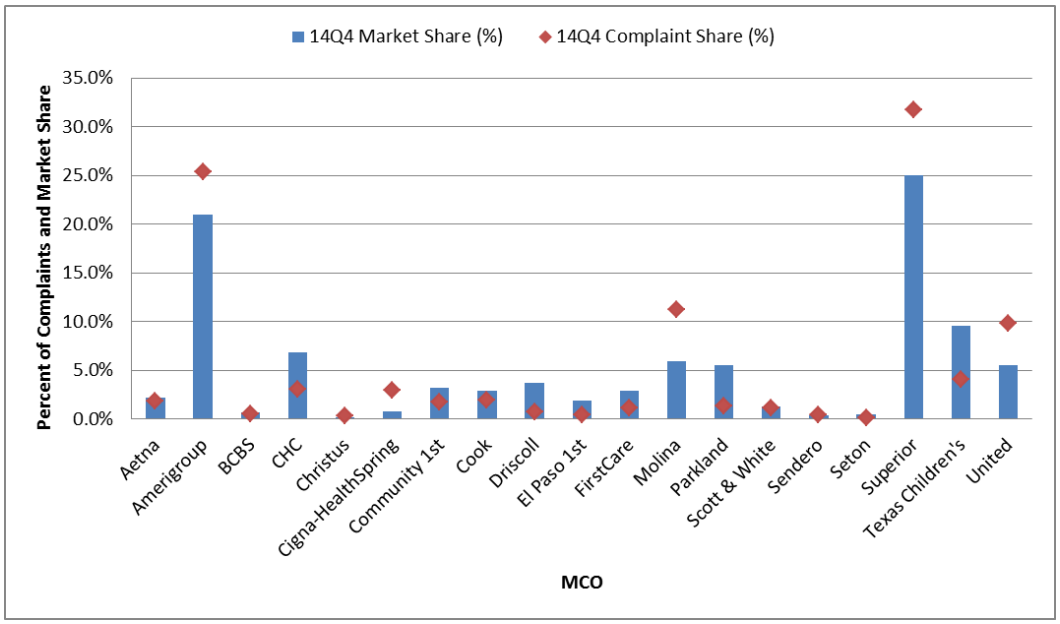


Figure 22: Complaints to the State Regarding STAR+PLUS (2014 Q1 – 2014 Q1)



The figure below displays the percent of complaints received by each MCO as well as their percent of market share in 2014 SFQ4. Compared across MCOs, the percent of complaints received was mostly equivalent to the percent of market share. Five plans received a significantly lower percentage of complaints compared to percent of market share: Community Health Choice, Community First, Driscoll, Parkland, and Texas Children's. Alternately, all five STAR+PLUS MCOs were responsible for a higher share of complaints when compared to their percent of market share.

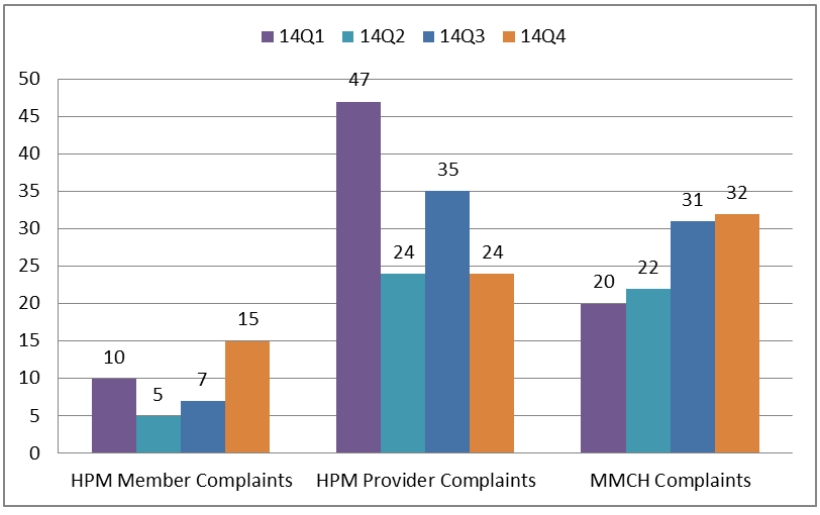
Figure 23: Complaints to the State as a Percentage of Market Share (2014 Q4)



2. Dental Program

The number of member complaints received by HPM regarding the dental program increased significantly (114 percent) in 2014 SFQ4. The number of MMCH complaints received about the dental program increased by only 3 percent and the number of provider complaints received by HPM decreased by 31 percent in SFQ4. The most common complaint type was denial of authorization of care. DentaQuest received 13 percent more complaints than MCNA. For both dental plans, roughly 30 percent of the complaints received were substantiated.

Figure 24: Complaints to the State Regarding the Dental Program (2014 Q1-Q4)



X. QUALITY ASSURANCE/MONITORING ACTIVITY

A. INCENTIVE/DISINCENTIVE PROGRAMS

During the reporting period, HHSC decided to eliminate risk adjustment by census tract poverty and service area from the 2013 At-Risk/Quality Challenge Program and the 2014 Pay-for-Quality (P4Q) Program. The decision to remove these risk adjustors was based on HHSC's recognition of the managed care organizations' (MCOs) need for more certainty and predictability of performance to meet HHSC's metrics for the P4Q program. HHSC also made some adjustments to the P4Q measures and provided the MCOs with interim baseline results for P4Q.

HHSC implemented capitation rate reductions for MCOs based on performance of hospitals on potentially preventable readmissions (PPR) and potentially preventable complications (PPC). The revised capitation rate is calculated by factoring in an adjustment based on hospitals that had an actual to expected ratio of potentially preventable readmissions and complications above 1.10 (statewide risk adjusted norm is 1.00), in accordance with the HHSC rules MCOs were provided a list of hospital PPR and PPC performance for FY2013 which MCOs could use to adjust their network provider payments.

HHSC also implemented hospital fee-for-service rate reductions based on performance on PPRs and PPCs. HHSC provided reports to each of the hospitals outlining their performance on these quality measures and has been fielding questions from the hospitals about the program and their specific reports.

B. PUBLIC REPORTING

As part of its quality strategy, HHSC is working to strengthen public reporting and to increase transparency and accountability of services and care being provided under the Texas Medicaid system. This is congruent with legislative initiatives from the 83rd Legislative Session, 2013 that mandate or suggest increasing public reporting (e.g., S.B. 7, S.B. 126).

As directed by Senate Bill 7, 82nd Legislature, First Called Session, 2011, HHSC continues to develop MCO report cards to help members of STAR, STAR+PLUS, and CHIP identify and select a health plan. During SFQ4, HHSC began the process of updating the report cards for 2015. Similar to the last round of report cards, a separate report card will be developed for each service area to provide information on the performance of each MCO with respect to outcome and process measures. Results will allow members to easily compare MCOs on quality domains of interest to them. The 2015 reports cards will be made available to members on the HHSC

website and will be included in the enrollment packets sent to all newly eligible members. The measures will continue to be reviewed and updated annually.

HHSC has developed a dedicated quality website to provide information on quality initiatives and projects that are currently occurring at HHSC. The Medicaid quality website serves as a central location for the public and other stakeholders to access information related to Medicaid quality with the aim of promoting transparency. The intent of this website is to consolidate and increase the availability of information related to Medicaid quality. For additional information, please visit the Medicaid and CHIP Quality and Efficiency Improvement webpage: http://www.hhsc.state.tx.us/hhsc_projects/ECI/index.shtml.

The Texas Healthcare Learning Collaborative Portal is an interactive website that presents quality of care data graphically. The measures presented report members' access to and utilization of preventive care, the occurrence of potentially avoidable hospitalizations, and effectiveness of care and treatment for behavioral and respiratory conditions. Data can be looked at by plan, program, and service area. HHSC made the portal available to the public during SFQ4. For additional information, please visit the portal: www.thlcportal.com

C. QUALITY IMPROVEMENT INITIATIVES

Senate Bill 7, 83rd Legislature, Regular Session, 2013, directed HHSC to carve Medicaid nursing facility services into managed care. This includes a requirement for a nursing facility-specific quality program. During the reporting period, HHSC finalized a set of quality indicators that will incentivize MCOs to ensure a high level of nursing facility quality of care. Proposed measures were posted for public feedback in July. Measures will be included in the 2015 dashboard.

HHSC is revising its performance improvement project (PIP) process in an effort to improve the quality of MCO PIPs. Recent changes extend all 2014 PIPs until at least 2015 and make future PIPs two-year projects. Additionally, HHSC conducted individualized technical assistance calls for all MCOs that scored five percent or more below average on at least one of their PIPs.

HHSC will study appointment availability for members seeking primary care services, behavioral health services, prenatal care, and vision care as outlined in the managed care contracts between HHSC and the MCOs. Samples of providers will be pulled from current provider directories submitted to ICHP by the Texas STAR, CHIP, and STAR+PLUS MCOs. Posing as providers, ICHP will call new patients in order to assess access to providers and the availability of appointments.

The HHSC Quality Improvement Strategy was approved by CMS in June. HHSC is working on a comprehensive strategy consistent with the requirements in the Texas Healthcare Transformation and Quality Improvement Program, STC 27(i).

The National Association of States United for Aging and Disabilities (NASUAD), in collaboration with the Human Services Research Institute (HSRI) and the National Association of State Directors of Developmental Disabilities Services (NASDDDS), has developed the NCI-AD survey, which is intended to obtain feedback from older adults and individuals with physical disabilities accessing publicly-funded long-term services and supports on their experience receiving those services. Texas has elected to participate in this project, which will include members of the STAR+PLUS program. During SFQ4 HHSC participated in webinars hosted by NASUAD.

No EQRO reports were due to HHSC in the fourth quarter.

XI. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 65, regarding evaluation activities and issues.

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from July 1, 2014 through September 30, 2014. The Program includes two interventions:

1. Intervention I

The expansion of the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, creating a new children's dental program, while carving-in prescription drug benefits; and

2. Intervention II

The establishment of two funding pools that will assist providers with uncompensated care costs and promote health system transformation.

The Program evaluation will examine the implementation and impact of the Program through a set of quarterly and annual performance measures throughout the demonstration period (December 12, 2011 through September 30, 2016). The principal focus of the demonstration

evaluation will be on obtaining and monitoring data on performance measures for short-term (process measures) and intermediate (health outcomes) of the Program. The performance measures will be used to assess the extent to which the Program accomplishes its goals, track changes from year to year, and identify opportunities for improvement.

This report identifies:

- the current quarter's evaluation activities,
- any challenges or issues encountered, and
- planned evaluation activities in the next quarter.

B. SUMMARY OF EVALUATION ACTIVITIES RELATED TO THE QUARTERLY

1. Joint Evaluation Activities (HHSC and Texas A&M): Interventions I & II

- HHSC SDS and Texas A&M attended monthly meetings and continued discussions regarding evaluation activities, including data collection, data requests, analysis, and preliminary results.
- HHSC SDS and Texas A&M met with Melissa Rowan, Healthcare Policy Director at Texas Council of Community Centers, to review proposed sites for Texas A&M's Primary/Behavioral Healthcare Integration case study.
- HHSC SDS and Texas A&M corresponded regarding the Primary/Behavioral Healthcare Integration case study scope of work and survey instruments.
- HHSC SDS and Texas A&M evaluation team members attended the Statewide Learning Collaborative Summit in Austin, TX on September 9-10. DSRIP performing providers from around the state shared lessons learned, discussed challenges to DSRIP project implementation, and received technical assistance from HHSC. Texas A&M presented preliminary results of the inter-organization network survey and the member and stakeholder survey titled "Evaluation of the Texas Healthcare Transformation and Quality Improvement Program: 1115(a) Medicaid Demonstration Waiver." HHSC SDS obtained feedback from stakeholder attendees on Texas A&M's preliminary evaluation findings and discussed this feedback with Texas A&M researchers.
- HHSC SDS and Texas A&M developed an interim report outline and timeline for review and submission.

2. HHSC Evaluation Activities: Interventions I & II

General Evaluation Activities:

- HHSC SDS Evaluation staff attended project meetings and scheduled monthly CMS calls.
- HHSC SDS continued meetings with HHSC Waiver team to discuss roles/responsibilities of learning collaborative, updates on data access, and identifying external evaluation partners who express an interest in collaborating on the evaluation of the demonstration.
- HHSC SDS attended Regional Healthcare Partnership (RHP) anchor calls.
- HHSC recruitment and selection of Research Specialist V candidates are ongoing.

Intervention I

- HHSC SDS continued to document an Intervention I evaluation plan protocol which includes stratification methodology.
- HHSC SDS continued to identify and collect baseline data for Intervention I.
    - Fee-for-service claims and Managed Care encounters
    - Eligibility files
- HHSC SDS reviewed the proposed budget and developed the scope of work for the data request submitted in June to Institute for Child Health Policy (ICHP), the Texas HHSC EQRO (External Quality Review Organization). The requested data will allow HHSC to leverage qualitative data captured through the Consumer Assessment of Health Providers and Systems (CAHPS) surveys and Healthcare Effectiveness Data and Information Set (HEDIS) measures for waiver evaluation activities.

Intervention II

- A formal research proposal was received on February 5, 2014. The Meadows Mental Health Policy Institute has agreed to provide the IGT funds for Texas A&M researchers to evaluate DSRIP projects integrating primary care into behavioral health settings for adults with severe and persistent mental illness (SPMI). HHSC SDS is currently amending the contract with Texas A&M to include this new scope of work.
- HHSC SDS began thematic content analysis of RHP needs as identified in the community needs assessment. This analysis allows for identification of themes (needs) identified across the state.
- HHSC SDS met with researchers from the University of Texas, School of Social Work (UTSW) regarding the methodology used in their descriptive analysis of mental health and behavioral health DSRIP projects. UTSW shared lessons learned and strategies for more efficient use of a database.

3. Texas A&M Evaluation Activities: Intervention II

Evaluation Goal 5

- HHSC notified the evaluation team that no further demonstration year (DY) uncompensated care (UC) data would be provided for preparation of the Interim Report.
- The Interim Report will cover SFY 2008-2012, including UC data in only DY1 (SFY2012), affording a one-year post intervention assessment of changes in UC.
- We determined the base project plan for UC Interim Report based on the HHSC Interim Report Schedule.

Evaluation Goal 6-8

- A continuing review application was completed and approved for Texas A&M protocol #2013-0457.
- Texas A&M research staff conducted phone surveys with the final 25 individuals in this sample.
- Preliminary analyses of wave 1 patient phone survey data began (e.g., confirmatory factor analyses).
- The patient phone survey was revised for wave 2 to eliminate non-essential questions, and sent to A&M's survey research center to begin the second round of surveys of the individuals who had completed phone surveys in round 1.
- One case study site became operational and Texas A&M research staff gained approval from that hospital's Institutional Review Board. Data collection for the site was initiated on September 29, 2014; five professionals were interviewed.
- Coding for the qualitative interview data commenced during this quarter.

Evaluation Goal 9

- Texas A&M continued data cleaning and analysis for each RHP.
- Texas A&M prepared preliminary results for overall collaboration in each RHP and presented at the HHSC Statewide Learning Collaborative Summit on September 10, 2014. Data analysis for measures of specific types of collaboration (sharing programs and services, sharing tangible resources, and data sharing) are ongoing.

Evaluation Goal 10-11

- Texas A&M prepared a cleaned data file for analysis, allowing for analysis at the RHP level.
- Texas A&M initiated quantitative and qualitative analyses.

- Texas A&M prepared preliminary results for survey questions related to DSRIP and presented at the HHSC Statewide Learning Collaborative Summit on September 10, 2014.

Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)

- Through the auspices of the Texas Council of Community Centers, on August 13, 2014 the study team met in Austin with representatives of selected local mental health authorities (LMHAs) to explain the study and seek their participation.
- The study team made follow up calls to potential participants to begin scheduling site visits for the fall of 2014.
- The study team refined instruments for site visits.

4. Challenges or Issues Encountered

One of the DSRIP projects selected for the case study evaluation did not become operational until 9/30/2014 (the last day of DY3 Q4); therefore, data collection will occur later, at least one month after the project becomes operational.

C. ACTIVITIES PLANNED IN NEXT QUARTER

From October 1, 2014 through December 31, 2014, HHSC will perform the following activities:

- HHSC SDS will attend project meetings and monthly CMS calls.
- HHSC SDS and Texas A&M will continue to meet monthly or semi-monthly to collaborate and provide feedback on each other's evaluations.
- HHSC SDS, HHSC Waiver Operations, the Meadows Mental Health Policy Institute, and UT Austin will continue to collaborate and provide feedback on the behavioral health project.
- HHSC SDS and Texas A&M team members will attend the 142nd Annual meeting and exposition of the American Public Health Association (APHA) conference (November 15 – 19, 2014). Team members will facilitate two oral presentations, one poster session, and one round table:
- Using quality measures to monitor and evaluate the impact of pharmacy carve-in implemented through an 1115(a) demonstration waiver: The Texas healthcare transformation and quality improvement program [#312530 Tue., 11/18/14, 12:30-1:30 p.m.]

- Texas Healthcare Transformation and Quality Improvement Program: Impacts of Medicaid policy change on quality of care for aged and disabled population [#311663 Wed., 11/19/14, 8:30 – 8:45 a.m.]
- A pragmatic approach to guide the design of a mixed methods evaluation of a Medicaid 1115(a) waiver: The Texas healthcare transformation and quality improvement program [#306136 Wed., 11/19/14, 8:50 – 9:10 a.m.]
- Applying health service utilization models to the Texas Health Transformation and Quality Improvement Program: Advancing theory-based evaluation [#3040.0 Mon., 11/17/14, 8:30 – 10 a.m.]

Intervention I

- HHSC SDS will continue to gather baseline data for Intervention I.
- HHSC SDS will continue to develop Intervention I evaluation plan protocol which includes stratification methodology for inclusion.

Intervention II

- Texas A&M will begin planning for the April 24, 2015 External Evaluator's Meeting in Austin, Texas.
- 2012 and beyond UC data is cost based, and requires application of charge-to-cost ratios to convert pre-2012 (2008-2011) charges to post 2012 costs, and perhaps vice versa, depending on which approach provides the highest validity.
- A draft outline of the interim report for Evaluation Goal #5 (EG5) will be modified based upon input from HHSC SDS leadership, and the limitation of only DY1 data available for analysis.
- The team will modify the EG5 evaluation plan to accommodate the data availability change, and submit the intro and methods for the interim report to the evaluation team.
- Professional and patient interviews for 2 selected sites whose care navigation projects are not yet operational will be initiated.
- The Texas A&M team will calculate descriptive statistics from patient phone survey data as well as the Relational Coordination portion of the professional interviews.
- Data collection for wave 2 of the patient telephone surveys will be initiated.
- Data analyses on the inter-organizational network survey will continue and be finalized.
- Qualitative and quantitative data analysis on the stakeholder survey results will continue and be finalized.
- Preparation of a technical report of results from the inter-organizational network survey (EG 9) and the member and stakeholder survey (EG 10-11) will commence.
- Preparation of the Interim Report will continue.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

The study team will initiate site visits.

XII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

A. ACCOMPLISHMENTS

1. Major DSRIP Activities during Federal Fiscal Quarter 1/2013 (10/01/2013-12/31/2013)

In Q1, CMS released their findings from their second review of the 48 remaining Phase 1 projects. 46 of the 48 projects were approved, though 11 were approved at a lower value than the provider requested. Of the 1322 projects initially submitted, as of December 31, 2013, 1258 had been approved, 41 were withdrawn, and 21 replacement projects had been proposed (to replace 23 initially submitted projects). Approved projects received DY2 DSRIP payments of about $506 million paid in November 2013 based on August reporting. DSRIP payments based on DY2 October reporting were disbursed in FFY2014 Q2.

Preparing for and processing October DY 2 DSRIP reporting was a large focus of Q1. HHSC received October reporting from over 320 providers (if a provider participated in more than one RHP, they were counted for each RHP) for over 1,250 Category 1 or 2 projects, 1,800 Category 3 outcomes, and over 150 Category 4 hospital reports. Most metrics (over 93 percent) were approved for the October reporting period for an estimated $1.088 billion in DSRIP payments.

Phase 4 of waiver implementation began in Q1. Phase 4 addressed priority technical corrections to providers' milestones and metrics and plan modification requests. In early December 2013, HHSC received 542 plan modification requests for over 300 approved DSRIP projects. Review of Phase 4 milestone/metric corrections and plan modifications continued in Q2, including an opportunity for RHPs to respond to requests for additional information.

In late December 2013, RHPs submitted 234 additional 3-year projects (to operate in DYs 3-5) to potentially earn almost $1.2 billion in remaining unallocated DSRIP funds.

HHSC provided targeted technical assistance sessions at the request of RHPs, hosted bi-weekly Anchor calls, presented to the Executive Waiver Committee, and held webinars for performing providers on completion of the October DY2 reporting template, completion of Phase 4 workbooks, submission of new 3-year DSRIP projects, and an overview of the DSRIP payment process.

2. Major DSRIP Activities during Federal Fiscal Quarter 2/2014 (01/01/2014-03/31/2014)

In Q2, HHSC submitted replacement projects to CMS on January 10, 2014, for review and approval. Approvals were received from CMS in early March for all 19 replacement projects (two of the original 21 replacement projects were withdrawn). These projects were eligible to report in April for DY3 reporting.

In late January and early February of 2014, HHSC staff reviewed provider responses to metrics that were found to need more information to support achievement during October DY 2 DSRIP reporting. Approvals and denials of the additional information submitted were sent to providers in early March. Those metrics that were approved were eligible for payment in July 2014. For project metrics achieved in DY2, DSRIP providers received about $1.6 billion in January 2014.

During Q2 HHSC staff reviewed all of the Phase 4 submissions from Q1, and feedback was provided to RHPs in late January and early February. HHSC approved many plan modification requests, but those that reduced the scope of activities or quantifiable patient impact were flagged for mid-point assessment. RHPs were given time to return responses to HHSC for those plan modifications still requiring information before they could be approved.

In Q2 HHSC began reviewing the 234 additional 3-year projects submitted by RHPs in December, and sending feedback to RHPs. HHSC began with reviewing projects from the four RHPs (5, 8, 17 and 20) that were only able to use very little of their DSRIP allocation in the initial plan submission due to lack of intergovernmental transfer (IGT) funds for the non-federal share.

HHSC continued focusing significant time and staff resources during Q2 on working with CMS on changes to Category 3, including the framework for earning funds, the outcome measure options in the RHP Planning Protocol and the standard target setting methodology for pay for performance measures. The final Category 3 Framework was approved in early February 2014. During Q2 HHSC continued to update Category 3 measures as HHSC gathered additional information on benchmarks, measure frequencies and available tools. Providers were required to submit their Category 3 outcome selections by March 10, 2014, in order to be eligible to report in April 2014 on DY3 metric achievement. Providers could also opt to submit their Category 3 selections by March 31, 2014, if they planned to report milestone status during the October DY3 reporting period. HHSC prepared tools and offered technical assistance to help providers make their Category 3 selections.

In Q2, HHSC continued to work with its Medicaid External Quality Review Organization (EQRO) and CMS to finalize the process for the Category 4 potentially preventable event (PPE) reporting domains that hospitals will be reporting and for which HHSC will provide the data. The initial data was sent to providers in April (Q3) in order to be used for April DY3 reporting.

HHSC provided targeted technical assistance sessions at the request of RHPs, hosted bi-weekly Anchor calls, presented to the Executive Waiver Committee, and held four webinars and/or conference calls coordinated with stakeholder partners to provide Category 3 Technical Assistance to DSRIP performing providers.

3. Major DSRIP Activities during Federal Fiscal Quarter 3/2014 (04/01/2014-06/30/2014)

In Q3, HHSC continued to review the 234 additional 3-year projects (to operate DYs 3-5) that RHPs submitted in December 2013. HHSC submitted 232 of the proposed 3-year projects to CMS in early May for approval, and CMS approved all 232 projects in late May 2014. HHSC worked with the regions and CMS to confirm valuation for each project and redistribute funds among regions. There ultimately was enough funding available in the RHPs for 217 3-year projects to move forward.

HHSC continued to work during Q3 with CMS on DY4-5 valuation for the 4-year projects based on information HHSC submitted to CMS in September 2013. There were 14 remaining projects out of the original 122 projects with state or CMS flags for potential overvaluation that chose to provide justification for their valuation rather than opt for a lower valuation or increase in QPI. In April, CMS issued a preliminary approval of the DY4-5 valuations for all but these remaining projects, but they also indicated that they would not issue formal valuation approvals for DY4-5 until after the mid-point assessment, in case the mid-point assessment leads to valuation changes.

In Q3, HHSC continued to lay the foundation for DSRIP monitoring efforts. Vendor proposals were due April 1, 2014. The compliance monitoring contract was awarded in May to the auditing firm Myers & Stauffer, LLP, which is conducting the midpoint assessment and also do ongoing compliance monitoring. Given the scope of Texas DSRIP and CMS resource limitations, CMS has asked HHSC to rely on Myers & Stauffer as the independent assessor going forward to double check HHSC's review work on new projects, plan modifications, etc. Issues will only be elevated to CMS for a decision if there is a discrepancy between the independent assessor's recommendation and HHSC's decision.

HHSC continued focusing significant time and staff resources during Q3 on Category 3, including the framework for earning funds, the outcome measure options in the RHP Planning Protocol and the standard target setting methodology for pay for performance measures. In Q3 HHSC reviewed provider Category 3 outcome selections that were submitted in March 2014 and began submitting feedback to providers.

April 2014 was the first opportunity for providers to report achievement of DY3 metrics along with reporting metrics carried forward from DY2. Provider reports were due April 30, and HHSC began reporting review in May and completed it in mid-June. Providers were sent reporting feedback via coversheets in late June and given three weeks to respond to requests for

additional information to support achievement of some metrics. Similar to prior reporting periods, HHSC was able to approve the majority (over 90%) of metrics reported. During Q3 HHSC continued to work with a consultant on the development of an automated system for DSRIP reporting, which was deployed in time for October DY3 reporting.

CMS approved updates to both DSRIP protocols, the Program and Funding Mechanics (PFM) Protocol and the RHP Planning Protocol (for Categories 1, 2 and 3), as well as some updates to the Special Terms and Conditions, in May 2014. CMS also approved the final Anchor Administrative Claiming Protocol in May.

HHSC continued stakeholder communications in Q3 through responses to technical assistance requests, biweekly Anchor calls, an Executive Waiver Committee meeting, companion documents, and a webinar to provide technical assistance to DSRIP providers on April reporting.

4. Major DSRIP Activities during Federal Fiscal Quarter 4/2014 (7/01/2014 - 9/30/2014)

In Q4, HHSC continued reviewing performing providers' Category 3 outcome selections that were submitted to HHSC in March 2014 and sending feedback to providers in order to ensure final Category 3 selections were approved in time for reporting baselines during the October 2014 reporting period. Staff devoted significant time providing technical assistance around Category 3 outcomes and baseline measurements conducting at least 600 conference calls with providers. HHSC, along with 3M Health Information Systems, also provided a technical assistance webinar for 470 participants around risk adjustment for Category 3.

During Q4, HHSC reviewed the additional reporting information submitted by providers that HHSC had requested in support of achievement of metrics reported in April 2014. Payment for metrics achieved in April reporting (and for which IGT was received) was sent out by July 31, 2014. Providers received approximately $693 million all funds for DY2 and DY3 metrics reported and achieved. During Q4 HHSC continued to work with a consultant on the development of an automated system for DSRIP reporting, which was deployed in time for October DY3 reporting.

In July and August, providers submitted 1,915 plan modification and technical change requests for HHSC review and approval. These requests were to make changes and updates to their project narratives and milestones and metrics. This change request period was the last opportunity for providers of 4-year DSRIP projects to initiate plan modification requests and technical change requests for DYs 4-5 for most issues. There will be some additional plan modifications initiated by HHSC/the compliance monitor during the midpoint assessment review. HHSC began reviewing the change requests during Q4FFY2014, with work continuing into the first quarter of FFY2015.

HHSC continued working with Myers & Stauffer, LLP, the auditing firm conducting the midpoint assessment and ongoing compliance monitoring. In September, Myers & Stauffer began the mid-point assessment review. 677 projects were selected for the midpoint assessment review based on the following: a) project options that were requested to be reviewed by CMS (1.10, 2.4, 2.5 and 2.8 and projects that were approved under "other" project option); b) projects flagged by HHSC during approval, plan modification and reporting reviews; and c) projects selected via random sampling.

HHSC continued stakeholder communications in Q4 through responses to technical assistance requests, biweekly Anchor calls, an Executive Waiver Committee meetings, companion documents, and webinars to provide technical assistance to DSRIP providers on the process for submitting Plan Modification and Technical Change requests and on Risk Adjustment Methodology for Category 3. HHSC also held a Statewide Learning Collaborative Summit, discussed more fully below.

In accordance with STC 14, Post Award Forum, HHSC afforded the public with an opportunity to provide comment on the progress of the Demonstration at the quarterly HHSC Stakeholder Forum, held on July 14, 2014. The date, time and location of the Stakeholder Forum were published on the HHSC website at least 30 days prior to the date of the forum. The HHSC Stakeholder Forum is open to the public. HHSC staff presented an overview of progress to date on the demonstration waiver and took questions and feedback from those in attendance. An archived recording of the forum is posted on the HHSC website.

5. Major UC Program Activities During DY3

January 2014

- HHSC issued a combined Disproportionate Share Hospital/Texas Hospital Uncompensated Care (DSH/TXHUC) DY2 application tool and the Texas Physician Uncompensated Care (TXPUC) application to providers

February 2014

- Completed DY2 DSH/TXHUC and TXPUC application tools received from providers

March – May 2014

- HHSC processed applications.
- Calculation of hospital specific limits (HSLs) verification by consultant and by provider applicants.

June 2014

- HHSC processed a 2013 DY2 Final UC Payment totaling $ 2,309,120,504 in June 2014

August 2014

- HHSC issues combined DSH/TXHUC DY3 application tool and the TXPUC application to providers

December 2014

- HHSC processed a 2014 DY3 Advance Waiver Payment totaling approximately $1,205,404,542.34 ($40,000,000 had been paid out earlier in August at one provider's request)

6. Upcoming UC Program Events in DY4

November 2014 - February 2015

- HHSC processes DSH/UC applications
- Calculation of HSLs occurs and verified by provider applicants

March 2015-April 2015

- Calculation of DSH/UC Payment amount

June 2015

- Final DY3 payments made to providers

7. Statewide Learning Collaborative Summit

On September 9-10, 2014, HHSC held a two-day Statewide Learning Collaborative Summit in Austin. The purpose of the Summit was to share what Texas DSRIP participants have learned from DSRIP in order to increase success in years 4 and 5 of the waiver. Attending the conference in person were approximately 470 people representing a wide variety of providers and projects across all 20 RHPs as well as other DSRIP stakeholders, and there was live stream web video capability for up to 1,000 others to view remotely.

Speakers included Cindy Mann, CMS Director; Dr. Betsy Shenkman from the University of Florida Institute for Child Health Policy, who spoke on alignment of Medicaid managed care and DSRIP; Dr. Guy Clifton with Clifton Health Centers, who spoke on integrated care delivery; and Dr. Andy Keller with the Meadows Mental Health Policy Institute, who spoke on DSRIP and behavioral health. There were also moderated panels on regional collaboration and learning collaborative best practices; highlights of DSRIP projects covering a range of providers, clinical

services and populations; and integrated approaches to care delivery in urban and rural settings. Smaller breakout sessions included technical assistance on reporting Quantitative Patient Impact (QPI), Category 3 risk adjustment and baseline setting, and Midpoint Assessment; issues and opportunities specific to rural and small providers; Continuous Quality Improvement; and an overview of early findings from the formal Texas 1115 Waiver Evaluation. There was also a Poster Session for innovative DSRIP projects to highlight their progress and successes.

8. Summary of RHP Milestone Achievement in DY3

Each of the 20 RHPs submitted an annual report to HHSC by December 15, 2014, that outlines the activities and achievements of the RHP for DY3. Those reports will be made available to CMS for review. HHSC also is providing a high-level summary of performance achievement by each RHP based on the two DY3 reporting periods – April 2014 and October 2014. This data is included in Attachment W. Please note that the eligible payment amounts are contingent on available intergovernmental transfer (IGT) funds, so actual payments likely will be a little lower than eligible payments.

As required in the Program Funding and Mechanics Protocol, each Anchoring Entity submitted a DY3 Annual Report by December 15, 2013. The reports include a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. The required data on the progress made for all metrics is contained in the attachment of the Summary of DY3 Reporting by RHP. A compressed file of all of the DY3 Anchor Annual Reports for all RHPs is included in Attachment W.

9. Projected DY4 DSRIP Payments

While HHSC's Financial Services staff will provide the official estimates of potential DSRIP payments to CMS for each quarter, based on April and October 2014 reporting, HHSC estimates that DSRIP providers will earn over $1 billion in DY4 DSRIP funds. This uses the same percentages as in DY3 reporting in which 20 percent was reported in April 2014, 94 percent of DSRIP reporting was approved by October 2014, and 12 percent of milestones/metrics were carried forward into DY4. It does not include DY3 metrics carried forward into DY4, so the total payment amounts for July 2015 (based on April 2015 reporting) and January 2016 (based on October 2015 reporting) likely will be higher that what is reflected below.

RHP	DSRIP Allocation DY4	Estimated April 2015 Reporting	Estimated October 2015 Reporting
RHP 1	$113,938,756	$18,850,028	$75,400,111
RHP 2	$97,754,063	$16,172,432	$64,689,729
RHP 3	$586,096,575	$96,963,817	$387,855,269
RHP 4	$117,980,988	$19,518,775	$78,075,098

RHP 5	$182,908,108	$30,260,317	$121,041,270
RHP 6	$302,245,811	$50,003,547	$200,014,188
RHP 7	$179,740,574	$29,736,281	$118,945,122
RHP 8	$27,749,012	$4,590,797	$18,363,186
RHP 9	$397,436,566	$65,751,905	$263,007,622
RHP 10	$291,686,901	$48,256,681	$193,026,724
RHP 11	$34,377,150	$5,687,356	$22,749,423
RHP 12	$108,840,237	$18,006,529	$72,026,115
RHP 13	$20,609,363	$3,409,613	$13,638,452
RHP 14	$68,706,341	$11,366,777	$45,467,108
RHP 15	$132,953,672	$21,995,856	$87,983,422
RHP 16	$40,595,216	$6,716,073	$26,864,290
RHP 17	$24,281,795	$4,017,180	$16,068,721
RHP 18	$31,763,486	$5,254,951	$21,019,805
RHP 19	$27,519,811	$4,552,878	$18,211,510
RHP 20	$27,590,105	$4,564,507	$18,258,028
Total	**$2,814,774,530**	**$465,676,298**	**$1,862,705,193**

POLICY, ADMINISTRATIVE AND FINANCIAL DIFFICULTIES

The Texas DSRIP program continued to evolve during DY3, encountering many policy and administrative challenges as HHSC, CMS, RHP anchors, and DSRIP providers worked to implement a DSRIP program that is very different than any other state's DSRIP program.

The volume and variety of providers (over 300) and projects (1,491) in Texas has led to the DSRIP program becoming extremely complex. The overarching challenge facing HHSC has been how to manage such a large, new program given aggressive timelines and limited resources. The HHSC waiver team now has 18 full-time positions (including three currently vacant positions) dedicated to DSRIP and a number of other staff within the agency playing key support roles for DSRIP. HHSC also relies heavily on a number of contractors to support DSRIP, including Deloitte Consulting, the Texas Medical Foundation (this contract ended 8/31/2014), Health Management Associates, Cooper Consulting, and Myers and Stauffer, LLC.

Timeline pressure up front resulted in more work later in the process. Multiple additional plan modification phases have had to be implemented since the initial review and approval of projects, including two rounds of comprehensive review of corrections to project narratives and milestone/metrics tables. There also continue to be multiple amendments to the protocols to further refine and strengthen the program. These changes midstream have been challenging for providers as they work not only to implement their projects, but also to understand and comply with requirements added or changed after they developed their projects.

At the end of May, our project officer, Rob Nelb, moved on from CMS. Rob had been part of the development of the Texas DSRIP waiver since it was first approved, so his leaving was a challenge for our work in progress. Before he left, Texas was able to memorialize understandings we had reached with him over the first 2 ½ years of the waiver in the Program Funding and Mechanics Protocol and the RHP Planning Protocol, and process the final approval of the Administrative Cost protocol so they are part of the DSRIP record for Texas. CMS has since appointed a new project officer for Texas, Brenda Blunt, who has worked diligently to be responsive to the Texas DSRIP program.

Category 3 and valuation review continued to be two of the most challenging policy areas in FFY2014, but approval of frameworks for both was acquired from CMS in May.

During Q4, HHSC realized that given the volume and complexity of DSRIP reporting anticipated in October 2014 (Q1 of FFY 2015), there would be no way that HHSC staff could review every metric and measure reported in October during the 30 days allowed for HHSC and CMS review. HHSC requested that due to the volume of projects and metrics, there be a new approach in October for managing the volume of reports. CMS worked with HHSC to add language to the Program Funding and Mechanics (PFM) Protocol to specify that HHSC and CMS may determine that a subset of not less than half of the projects and metrics will be reviewed during the 30 days after the reporting period. In such instances, HHSC and CMS will designate those projects and metrics that are not reviewed within 30 days as "provisionally approved." Such "provisionally approved" projects and metrics will be reviewed in full by HHSC prior to the next reporting due date in April 2015. For metrics that are "provisionally approved," the Performing Provider will receive full DSRIP payment in January 2015. After review of any "provisionally approved" item, additional information regarding the data reported for each milestone/metric will be requested if necessary, most likely in late February or early March 2015. If the initial supporting documentation, and any additional information, does not form a sufficient basis for actual metric achievement, HHSC will recoup the associated overpayments from the Performing Provider. As described in waiver rules, HHSC will withhold future payments until the recoupment occurs.

Finally, during Q4, the CMS Regional Office conducted a DSRIP Financial Management Review of four RHPs - RHPs 4, 7, 9 and 10. HHSC supplied CMS staff much information for this review and also helped coordinate with the impacted RHPs. While HHSC has not yet received a draft report from the review for comment (originally anticipated for late 2014), on September 30, 2014, CMS sent HHSC a notice of deferral of almost $75 million for private hospital UC payments in three of these regions for Q3. During Q1 of FFY2015, HHSC worked with CMS to get the deferral lifted, and HHSC's understanding from phone conversations with CMS staff in December 2014 is that CMS will issue a letter lifting the deferral to afford CMS and HHSC a year to resolve CMS financing concerns around how the non-federal share of payments for private hospitals is financed. This is a critical issue for Texas' safety net providers and the ongoing success of the DSRIP and UC programs.

ENCLOSURES/ATTACHMENTS

Attachment A – Health and Dental Plans by Service Area. The attachment includes a table of the health and dental plans by service areas.

Attachment B -- Enrollment Summary. The attachment includes annual and quarterly enrollment summaries for the three Waiver programs.

Attachments C1 and C2 – Network Summary and Methodology. The attachment summarizes STAR and STAR+PLUS network enrollment by managed care organizations, service areas, and provider types. It also includes a description of the methodology used for provider counts and terminations.

Attachments D1 and D2 – Out-of-Network Utilization. The attachments summarizes STAR and STAR+PLUS out-of-network utilization.

Attachment E – HHSC GeoMapping. The attachment shows the State's GeoMapping analysis for STAR and STAR+PLUS plans.

Attachment G – HHSC Pharmacy GeoMapping Summary. The attachment includes the State's pharmacy GeoMapping results.

Attachment H – HHSC Dental GeoMapping Summary. The attachment includes the results of the State's GeoMapping analysis for dental plans.

Attachment I –MCO GeoMapping Summary. The attachment includes the STAR plans' self-reported GeoMapping results.

Attachment J – MCO Pharmacy GeoMapping Summary. The attachment includes the STAR+PLUS plans' self-reported GeoMapping results.

Attachment K – MCO Children's Medicaid Dental Services GeoMapping Summary. The attachment includes the dental plans' self-reported GeoMapping results.

Attachment L – Enrollment Broker 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 as well as the MCO Behavioral Health Crisis Hotlines.

Attachments N1 and N2 – Complaints and Appeals to Managed Care Organizations. The attachment includes STAR and STAR+PLUS complaints and appeals received by plans.

Attachment O – Complaints to HHSC. The attachment includes information concerning complaints received by the State.

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

Attachment Q – Members with Special Healthcare Needs Report. The attachment represents total MSHCN enrollment in STAR and STAR+PLUS during the prior fiscal year.

Attachment R – Provider Fraud and Abuse. The attachment represents a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period, 2014 SFQ3-4.

Attachments T1-T4 – EQRO Quality Reports. The attachment includes draft reports from the EQRO on behavioral health, STAR+PLUS HCBS, STAR Adults, and the annual summary of activties.

Attachments V1-V3 – STAR and STAR+PLUS Claims Summary. The attachment is a summary of the managed care organizations' 2013 SFQ1 and SFQ2 claims adjudication results

Attachment W – DSRIP Reporting by RHP. The attachments includes a summary of the demonstration year 3 DSRIP reporting by RHP and annual reports from all anchors

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