Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2016 State Fiscal Quarter 2, December-January

Demonstration Year (DY) 5 January-March

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I. INTRODUCTION

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

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- 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 reporting requirements for the Delivery System Reform Incentive Payment (DSRIP) Regional Healthcare Partnerships (RHPs); the demonstration evaluation; budget neutrality; member months; operational, policy, systems, and fiscal issues; and action plans for addressing the identified issues. These requirements are found in the waiver's Special Terms and Conditions (STCs), items 50, 54, 66, 68, and 72. Information about the managed care Medicaid programs under the 1115 will be covered in a separate managed care quarterly report.

The State collects some data on a State Fiscal Quarter (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2016 SFQ2 (December-February) instead of Demonstration Year (DY) 5, Q2 ("2016 D2," covering January-March). Throughout the report, the State has identified whether the quarterly data relates to 2016 SFQ2 or 2016 D2.

A. 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 Regional Healthcare Partnerships 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.

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

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

This section addresses STC 68, 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 has not identified any 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.

Legacy Community Health Services, Inc., v. Janek (official capacity) and Texas Children's Health Plan. Filed on January 7, 2015, in the U.S. District Court for the Southern District of Texas. Plaintiff Legacy is a Federally Qualified Health Center (FQHC) and a Medicaid provider that was in Texas Children's Health Plan's (TCHP's) provider network. TCHP notified Legacy in December 2014 that Legacy was to be terminated as a provider in TCHP's plan. Legacy brought suit against both TCHP and HHSC's Executive Commissioner, alleging that HHSC's method of paying FQHCs is contrary to federal law. FQHCs are guaranteed an encounter rate calculated under a methodology prescribed under 42 U.S.C. §1396a(bb). HHSC ensures compliance with this provision by requiring MCOs to pay FQHCs the full encounter rate, and includes funds for such payments in the capitated rate paid to MCOs. Legacy asserts that HHSC must make supplemental ("wrap") payments directly to FQHCs. District Judge Keith Ellison conducted a hearing on January 28, 2015, and denied Legacy's request for a preliminary injunction. Legacy non-suited TCHP, but continues to maintain its claims against HHSC. Both Legacy and HHSC have filed motions for summary judgment and a ruling on those motions is anticipated by the end of June 2016.

Texas Children's and Seattle Children's Hospital v. Burwell (official capacity), Tavenner (official capacity), and CMS. Filed on December 5, 2014, in the U.S. District Court for the District of Columbia. District Judge Emmet Sullivan granted a preliminary injunction request by

Plaintiffs, and required CMS to discontinue enforcing its policy published as "FAQ Number 33" and involving the inclusion of revenues associated with patients having coverage under both Medicaid and private insurance. The court also expressly prohibited CMS from taking action to recoup past Disproportionate Share Hospital (DSH) program overpayments based on a state's compliance with FAQ No. 33.

HHSC notes that the same issue was litigated in state court. In 2013, Texas Children's Hospital (TCH) sued HHSC in state court alleging that by following CMS's FAQ 33, HHSC had improperly altered its method of calculating uncompensated care, adversely affecting TCH's disproportionate share and uncompensated care payments. That lawsuit was dismissed on March 29, 2014. However, TCH and co-plaintiff Seattle Children's now assert substantially the same theory against CMS in federal court litigation. Although HHSC is not a direct party to this federal litigation, HHSC recognizes that the outcome of this case could have a significant bearing on the hospital disproportionate share and uncompensated care payment programs. Until the issue is resolved with clarity, the litigation may result in delays and uncertainty concerning the appropriate method of making the uncompensated care calculations for future payments and for recouping past DSH and uncompensated-care overpayments.

Filed in 1993, *Frew, et al. v. Traylor, et al*. (commonly referred to as *Frew*), was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the federal Medicaid Act. The Texas EPSDT program, known as Texas Health Steps (THSteps), provides comprehensive and preventive medical and dental services for children through age 20 enrolled in Medicaid. The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996. The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor compliance with the orders by the Texas Health and Human Services Commission (HHSC) and the Texas Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to 11 corrective action orders to bring the state into compliance with the consent decree and to increase access to THSteps services. The corrective action orders touch upon many program areas, and generally require the state to take actions intended to ensure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

In 2013, the U.S. district court vacated two of the eleven corrective action orders: (1) Check Up Reports and Plans for Lagging Counties, and (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, and related paragraphs of the consent decree, after finding

that the state defendants had complied with the required actions. The *Frew* Plaintiffs appealed the second order (regarding Prescription and Non-Prescription Medications, Medical Equipment, and Supplies) to the Fifth Circuit Court of Appeals. On March 5, 2015, the Fifth Circuit affirmed the district court's order vacating the corrective action order and related paragraphs of the consent decree, holding that the state had satisfied its obligations related to training Medicaid-enrolled pharmacists about EPSDT-covered pharmacy items. In February 2016, the U.S. Supreme Court denied the *Frew* Plaintiffs' petition for writ of certiorari seeking to have the Fifth Circuit's order reversed.

In 2014, the parties jointly agreed to vacate a corrective action order related to Toll-Free Numbers, and the related paragraph of the consent decree, for several Medicaid-related toll-free lines operated by the state and its contractors. The district court granted the parties' joint motion and vacated the toll-free numbers orders for all but one remaining helpline: a medical transportation line operated by one of the state's full-risk broker transportation contractors.

On January 20, 2015, the district court vacated a corrective action order related to an Adequate Supply of Health Care Providers and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. The Court found that the State had satisfied the terms of those orders by taking realistic and viable measures to enhance recipients' access to care through ensuring an adequate supply of healthcare providers (both primary care and specialists) by using targeted recruitment efforts, increasing reimbursement rates, and using best efforts to maintain updated lists of providers for recipients and other providers. In March 2016, the Fifth Circuit affirmed the district court's opinion vacating the decree paragraphs and most of the Adequate Supply of Health Care Providers corrective action order. The Fifth Circuit vacated and remanded to the district court for further proceedings the portion of the district court's order which held that the State had satisfied its obligation under the corrective action order to use provider assessments to identify provider "shortages" and implement corrective action based upon any shortages, because the parties and the district court did not define "shortages" correctly. Based upon the definition of "shortages" provided by the Fifth Circuit, the Fifth Circuit also vacated and remanded to the district court for further proceedings the portion of the district court's order which held that the State had satisfied its obligation under the corrective action order to have provider payment rates sufficient to attract enough providers to serve Medicaid recipients under age 21.

On September 28, 2015, the district court vacated two of the remaining corrective action orders: (1) Transportation Program, and (2) Health Care Provider Training, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions. Plaintiffs did not appeal those two district court orders.

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.

III. 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 68.

1. Litigation

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

2. Other

There were no fiscal or systems issues, or legislative activity that occurred in 2016 D2.

IV. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

This section addresses the quarterly reporting requirements in STC 66 and 68 regarding financial and budget neutrality development and issues.

There were no significant development issues or problems with financial accounting, budget neutrality and the CMS 64 and budget neutrality report for 2016 D2.

V. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements in STC regarding eligible member month participants in compliance with STC 54.

Eligibility Groups Used in Budget Neutrality Calculations (2016 D2)

Eligibility Group	Month 1 (Jan 2016)	Month 2 (Feb 2016)	Month 3 (Mar 2016)	Total for Quarter Ending Mar 2016
Adults	279,359	277,179	279,039	835,577
Children	2,629,772	2,633,719	2,619,921	7,883,412
AMR	363,450	364,215	362,697	1,090,362
Disabled	426,481	428,097	427,063	1,281,641

Eligibility Groups Not Used in Budget Neutrality Calculations (2016 D2)

Eligibility Group	Month 1 (Jan 2016)	Month 2 (Feb 2016)	Month 3 (Mar 2016)	Total for Quarter Ending Mar 2016
AMR in MRSA	-	-	-	-
Foster Care	32,446	32,907	32,931	98,283
Medically Needy	119	124	124	367
CHIP-Funded	271,600	272,116	272,534	816,249
Adoption Subsidy	46,946	47,174	47,404	141,524
STAR+PLUS 217-Like HCBS	10,800	10,807	10,829	32,435

VI. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 68 and 72, regarding evaluation activities and issues.

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from January 1, 2016 through March 31, 2016.

The Program includes two interventions:

> **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; nursing facility services; and, the behavioral health services of targeted case management and rehabilitative services (Evaluation Goals 1-4).
>
> **Intervention II**: The establishment of two funding pools that will assist providers with uncompensated care costs and promote health system transformation (Evaluation Goals 5-11).

The Program evaluation will examine the implementation and impact of the Program through a set of annual performance measures through year four of the demonstration period. 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

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

1. HHSC's Office of Strategic Decision Support's evaluation team ("HHSC SDS") and the Texas A&M School of Public Health, including its subcontractors the University of Louisville School of Public Health and Information Sciences and The University of Texas School of Public Health (collectively referred to as "Texas A&M"), attended monthly meetings and continued discussions regarding evaluation activities, including data collection, data requests, analysis, and preliminary results.

HHSC Evaluation Activities: Interventions I & II

General Evaluation Activities

1. HHSC SDS evaluation staff attended project meetings and scheduled monthly CMS calls.
2. HHSC SDS attended Regional Healthcare Partnership (RHP) anchor calls.
3. HHSC Research Specialist Sarah Roper-Coleman left her position in March to pursue another opportunity.

Intervention I

1. HHSC SDS received and responded to CMS feedback on the Interim Evaluation Report – hard copy responses were provided February 10, 2016 and a conference call attended on February 12, 2016 for any follow-up questions.
2. HHSC SDS continued to identify and collect data for Final Report analyses to Program demonstration years (DYs) 2014-2015.
    a. Fee-for-service claims and Managed Care encounters
    b. Eligibility files
3. HHSC SDS continued to explore multivariate modelling methodologies to utilize for the Final Report.

Intervention II

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

1. HHSC SDS participated in monthly meetings hosted by UT School of Public Health to collaborate and provide feedback on the evaluation project. Texas A&M School of Public Health, the Meadows Mental Health Policy Institute, and the Texas Council of Community Centers also attended.

2. HHSC SDS continued to provide feedback on measures and research methodology.

Texas A&M Evaluation Activities: Intervention II

Evaluation Goal 5

1. Incorporation of 2014 (data for FY2012) and 2015 (data for FY2013) into Uncompensated Care (UC) analysis
2. Introducing UC payment into the analysis of UC so that we are now able to quantify:
    a. Hospital shortfall
    b. Hospital shortfall less DSH payment
    c. Total shortfall less DSH payment (= hospital shortfall less DSH payment plus physician, clinic, and pharmacy)
    d. Total shortfall less DSH & UC payment: an estimator for UC
3. Notation of adjustment effects in 2014 &2015 data: recoupment and legal adjustment for class one hospitals
4. Regression and projection analysis for UC: found rural/urban status and ownership (private vs. public-non-state) as significant factor influencing UC

Evaluation Goals 6-8

1. The EG 6-8 evaluation plan was expanded, clarified, and resubmitted to HHSC SDS. This revised plan will provide the framework for the final report on EG 6-8
2. The final site visits for the comparative case study of Emergency Department (ED)-related care navigation were conducted (except one, where the sole care navigator is on maternity leave until mid-April). The final comparison site phone interviews were also conducted.
3. The survey research firm contracted to conduct the cohort two patient phone survey completed calling.
4. The second round of telephone surveying began with key partners about their interactions with the care navigation programs in the study.
5. The research team submitted a manuscript on the three Emergency Medical Service (EMS)-based care navigation projects in the study to the *Journal of Health Care for the Poor and Underserved*, for a special issue.
6. The UT and A&M IRBs approved procuring patient identifiers from two large intervention sites and two large comparison sites for the purpose of obtaining Medicaid utilization rates and discharge data from HHSC and DSHS for additional analyses of patient-level data.

Evaluation Goal 9

1. Texas A&M continued the second wave of data collection.
2. Texas A&M initiated qualitative analysis of T0 and T1 survey questions.
3. Texas A&M initiated revisions for the manuscript on EG9 findings submitted for publication in *Public Administration Review* (revisions due July 2016).

Evaluation Goal 10-11

1. Texas A&M initiated comparative analyses on EG 10-11 results in preparation for the final report.
2. Texas A&M started analysis of learning collaborative information for inclusion in the final report.

Texas A&M Evaluation Activities: Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)

1. The second round (one year after baseline) phone interviews with participating community mental health centers were completed in January 2016.
2. Texas A&M and UT IRBs approved requesting patient-level data from participating community mental health centers for analyses of patient outcomes before and after receiving integrated primary/behavioral health care.
3. The research team obtained IRB approval from DSHS for requesting discharge data using patient identifiers provided by participating community mental health centers for all patients who have received integrated primary/behavioral care in site projects.
4. Plans for patient measure construction and analyses were further refined.
5. Dr. Bobbie Kite joined the research team to prepare and analyze patient level data. Her biosketch is provided below:

   Bobbie Kite, PhD, MHS, is a faculty member in the Department of Health Professions & Health Care Management at the Metropolitan State University of Denver, and adjunct faculty in Healthcare Leadership in the University College of Professional and Continuing Studies at the University of Denver. Previously, she was a National Library of Medicine Fellow in the Clinical and Translational Informatics Training Program in the Department of Biomedical Informatics at the Ohio State University Wexner Medical Center, and worked as a consultant in clinical and population informatics and process development for the Ohio State University Health Plan. Dr. Kite holds a PhD in Management, Policy, and Community Health from the University of Texas School of Public Health and a MHS in emergency and disaster management from Touro University in California. Her current research focuses on the integration of disparate sources of data with clinical measurement guidelines (CMGs) and operation evidence in data fusion platforms to improve health and healthcare delivery while improving business outcomes.

Challenges or Issues Encountered

1. Procuring identified patient rosters for the patient phone survey from sites in the ED care navigation study continued to be a substantial challenge. In the end, all DSRIP CN sites and five of the remaining nine comparison sites provided rosters. Nonetheless, the sample size and variation of patients from participating comparison sites should be sufficient for analyses.
2. There is a scarcity of cost-related data for EG 8, examining the effect of DSRIP on cost outcomes. The research team is going to map average local ED costs onto patient survey responses about likelihood of returning to the ED. HHSC is also working to share discharge and potentially Medicaid claims data to measure the impact of DSRIP care navigation on inpatient and outpatient service use.

C. ACTIVITIES PLANNED IN NEXT QUARTER

(April 1, 2016 through June 30, 2016)

1. HHSC SDS will attend project meetings and monthly CMS calls, as well as RHP anchor calls.
2. HHSC SDS and Texas A&M will continue to meet at least monthly to collaborate and provide feedback on each other's evaluations.
3. Texas A&M will explore use of other data sources (e.g. HCRIS, Texas hospital discharge data, and Blue Ribbon data) and draft the final report for EG 5
4. HHSC SDS will have planning meetings with Texas A&M to discuss the development of those sections of the final evaluation report related to EG 5 and EG 6-8.

Intervention I

1. HHSC SDS will continue to gather baseline data for Intervention I for the Final Report. DY4 (the last year reported in the Final Report will become available in April 2016).
2. HHSC SDS will continue to explore an Intervention I evaluation plan protocol for the Final Report, which includes longitudinal methodology to examine the impact of Medicaid Managed care expansion.

Intervention II

1. The last wave 3 site visit for the ED care navigation study (EG 6-8) will be completed in May, after the care navigator returns from maternity leave.
2. Telephone surveying of key partners about their coordination with DSRIP ED care navigators will be completed.
3. The EG 6-8 team will continue preparing and analyzing data from site visits, the patient phone survey, and surveying of care navigation program's key partners for final analyses of whether and how DSRIP ED care navigation projects affected quality, health, and cost-related outcomes.
4. Texas A&M will finish data collection for EG 9, continue data cleaning, and initiate analyses.

5. Texas A&M will continue qualitative analysis of open-ended questions used in the first EG 9 survey.
6. The research team will begin drafting the final report based on HHSC SDS input, External Advisors' suggestion, and current study progress.
7. Manuscript preparation will continue.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

1. The research team will continue coding qualitative data from site visits and follow-up interviews with all sites.
2. The research team will secure patient data from participating community mental health centers.
3. HHSC will request discharge data from the Texas Department of State Health Services in order to measure patients' hospital, and potentially outpatient (Medicaid-billed) use before and after beginning integrated care.

VII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

In late January and early February of 2016, HHSC staff reviewed provider responses to metrics needing more information to support achievement during October DY 4 DSRIP reporting. Approvals and denials of the additional information submitted were given to providers the last week of February/first week of March. Those approved metrics will be eligible for payment in July 2016. For project metrics achieved during the October DY4 reporting period (including DY3 carryforward metrics), DSRIP providers received about $1.9 billion in January 2015. During Q2 HHSC posted the October DY4 payment summary by DSRIP project on the HHSC waiver website, along with the project and provider level summary reports. These reports provide high-level narratives overviewing the status of all provider's projects and project-level status information related to a specific project's accomplishments, challenges, lessons learned, etc.

HHSC completed review of the anchor administrative cost reports submitted during Q1. IGT was requested by January 28th with payments to anchors made February 12, 2016.

During Q2, significant work continued with Category 3. HHSC finalized review of Category 3 baselines submitted during the October DY4 reporting period. HHSC sent providers a summary of reported baselines and goals, in addition to notes about those baselines needing technical assistance. HHSC developed an Interim Category 3 Correction Template that providers were able to submit to make needed corrections to baselines (which included Pay for Performance outcomes that already reported DY4 performance, or those outcomes approved for an alternate achievement level, maintenance, or Pay for Reporting due to small volume) prior to April DY5 reporting. For all other outcomes, HHSC developed a Category 3 project specific reporting summary and goal calculator so that providers can confirm current reporting information and determine new goals if corrections are anticipated.

In Q2, HHSC continued laying the groundwork for the proposed waiver extension period. In January, HHSC began notifying individual providers of the results of the project review HHSC conducted during Q1. This review of projects was undertaken to determine if a project would be eligible to continue or requires changes for the waiver extension period. During project review, HHSC considered reported progress toward goals in addition to completion/incompletion of metrics; reported challenges and delays in implementing projects; transformative value of the project including whether the project option was removed from the 3-year project menu or draft extension menu; valuation and Medicaid Low-Income Uninsured (MLIU) impact of similar projects across the state; and any similar projects within the region. HHSC determined that almost all of the projects reviewed will be eligible to continue based on the review criteria noted above, but some will require strengthening or next steps, such as increasing Quantitative Patient Impact (QPI) and/or MLIU, requiring MLIU as pay for performance in DY6 and/or taking a logical next step to further transformation in DY6.

Also during Q2 and related to HHSC's waiver extension proposals, HHSC posted a template and companion document for providers to complete if they were interested in combining certain projects into a single project during the waiver extension period (DY6 - 10). The purpose of combining projects is to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information. Projects that may combine include cross-regional community mental health center (CMHC) projects; similar projects by the same provider within one region; or similar projects by different providers within the same health system and region. Through this process, the combined valuation of Category 1 or 2 projects may not exceed $5 million in each demonstration year, and combined projects must be from the same project area. Templates were due back to HHSC by early February 2016 and were reviewed by HHSC staff.

During Q2 HHSC also posted on the waiver website draft language for the Program Funding and Mechanics (PFM) Protocol relating to the transition year (DY6). A survey was available for stakeholder feedback on the proposed language. HHSC also posted a draft list of Performance Bonus Pool and Statewide Analysis Plan measures that builds on the information presented at the 2015 Statewide Learning Collaborative, with an ongoing opportunity for stakeholder feedback on these proposed measures. A list of best practice models HHSC identified for project options on the Transformation Extension Menu for replacement projects was posted, with a survey for stakeholder feedback on the Transformation Extension Menu.

In Q2, HHSC continued working with Myers & Stauffer on ongoing compliance monitoring, both review of Category 3 baselines and the beginning of validation of Category 1 & 2 metrics.

During Q2 HHSC staff worked on completing April DY5 reporting templates for QPI and Category 3 as well as an updated reporting companion documents for Category 1&2 and Category 3 reporting containing detailed instructions and examples.

Work with the Clinical Champions workgroup continued in Q2 with a meeting on February 5, 2016. Representatives from some Medicaid Managed Care Organizations (MCOs) were invited to continue the dialogue initiated at the 2015 Statewide Learning Collaborative, including how to establish and facilitate partnerships to further the alignment of DSRIP and MCOs. This will be a continuing area of focus for the Clinical Champions.

HHSC continued stakeholder communications in Q2 through biweekly Anchor calls and an Executive Waiver Committee meeting. On February 5, 2016, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on proposals for the Transition Year (DY6) of the waiver extension. HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2016 Q3.

ENCLOSURES/ATTACHMENTS

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.

STATE CONTACTS

For questions regarding the RHPs, UC, and DSRIP, please contact:

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ACRONYM LIST

AAA	area agency on aging
ADRC	Aging and Disability Resource Centers
APHA	American Public Health Association
BIP	Balancing Incentive Program
CAHPS	Consumer Assessment of Health Providers and Systems
CAP	corrective action plan
CFC	Community First Choice
CMS	Centers for Medicare & Medicaid Services
DADS	Department of Aging and Disability Services
DMO	dental managed care organization
DSH	Disproportionate Share Hospital
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	demonstration year
EB	enrollment broker
EG	evaluation goal
ENT	otolaryngologist
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	emergency room
ERS	emergency response services
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HPM	Health Plan Management
HSRI	Human Services Research Institute
ICF-IID	intermediate care facility for individuals with intellectual disabilities or a related condition
ICHP	Institute for Child Health Policy
ICSS	Independent Consumer Supports System
IGT	intergovernmental transfer
IMD	institution for mental disease
LD	liquidated damages
LTCO	long-term care ombudsman
MACPAC	Medicaid and CHIP payment and Access Commission
MAGI	modified adjusted gross income
MCO	managed care organization
MMCH	Medicaid Managed Care Helpline
MRSA	Medicaid Rural Service Areas
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NASHP	National Academy for State Health Policy

NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators-Aging and Disabilities
OON	out-of-network
P4Q	Pay-For-Quality
PBM	Pharmacy Benefits Manager
PIP	performance improvement project
PCP	primary care provider
PFM	Program Funding and Mechanics
RHP	Regional Healthcare Partnerships
SDA	service delivery area
SDS	HHSC Strategic Decision Support
SFQ	State Fiscal Quarterly
SMMC	State Medicaid Managed Care Advisory Committee
SPMI	severe and persistent mental illness
STCs	Special Terms and Conditions
TCH	Texas Children's Hospital
TCHP	Texas Children's Health Plan
THSteps	Texas Health Steps
UC	uncompensated care

Managed Care Hospital Transition 1115 waiver

Quarter Reporting Period

Q2 (Jan 2016 - Mar 2016)

Medicaid Eligibility Group			Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015
Adults	Caseload		283,113	279,896	276,783	839,792
	PMPM	Medical	*906.18*	*906.18*	*906.18*	*906.18*
		UPL	*199.00*	*199.00*	*199.00*	*199.00*
		STAR UPL	*0.00*	*0.00*	*0.00*	*0.00*
		STAR FFSE	*0.00*	*0.00*	*0.00*	*0.00*
	Cost	Medical	256,552,251	253,636,455	250,816,008	761,004,714
		UPL	56,338,889	55,698,580	55,079,210	167,116,679
		STAR UPL	0	0	0	-
		STAR FFSE	0	0	0	-
Children	Caseload		2,621,652	2,631,172	2,628,503	7,881,326
	PMPM	Medical	*316.99*	*316.99*	*316.99*	*316.99*
		UPL	*26.69*	*26.69*	*26.69*	*26.69*
		STAR UPL	*0.00*	*0.00*	*0.00*	*0.00*
		STAR FFSE	*0.00*	*0.00*	*0.00*	*0.00*
	Cost	Medical	831,046,555	834,064,352	833,218,245	2,498,329,153
		UPL	69,962,739	70,216,796	70,145,565	210,325,100
		STAR UPL	0	0	0	-
		STAR FFSE	0	0	0	-
AMR (non MRSA)	Caseload		364,111	364,377	361,407	1,089,896
	PMPM	Medical	*1,140.52*	*1,140.52*	*1,140.52*	*1,140.52*
		UPL	*3.63*	*3.63*	*3.63*	*3.63*
		STAR UPL	*0.00*	*0.00*	*0.00*	*0.00*
		STAR FFSE	*0.00*	*0.00*	*0.00*	*0.00*
	Cost	Medical	415,274,472	415,578,071	412,191,108	1,243,043,651
		UPL	1,323,053	1,324,020	1,313,229	3,960,302
		STAR UPL	0	0	0	-
		STAR FFSE	0	0	0	-
Disabled	Caseload		426,453	427,438	426,498	1,280,390
	PMPM	Medical	*1,538.16*	*1,538.16*	*1,538.16*	*1,538.16*
		UPL	*174.29*	*174.29*	*174.29*	*174.29*
		STAR UPL	*0.00*	*0.00*	*0.00*	*0.00*
		STAR FFSE	*0.00*	*0.00*	*0.00*	*0.00*
	Cost	Medical	655,955,665	657,470,583	656,024,786	1,969,451,035
		UPL	74,324,483	74,496,134	74,332,315	223,152,932
		STAR UPL	0	0	0	-
		STAR FFSE	0	0	0	-
Total	Caseload		3,695,329	3,702,883	3,693,192	11,091,404
	PMPM	Medical	*584.20*	*583.53*	*582.76*	*583.50*
		UPL	*54.65*	*54.48*	*54.39*	*54.51*
		STAR UPL	*0.00*	*0.00*	*0.00*	*0.00*
		STAR FFSE	*0.00*	*0.00*	*0.00*	*0.00*
	Cost	Medical	2,158,828,944	2,160,749,462	2,152,250,148	6,471,828,553
		UPL	201,949,164	201,735,530	200,870,319	604,555,013
		STAR UPL	0	0	0	-
		STAR FFSE	0	0	0	-
	Total		2,360,778,108	2,362,484,992	2,353,120,467	7,076,383,566
	Other UPL Programs		145,084,109	145,084,109	145,084,109	435,252,328

WOW Grand Total	2,505,862,217	2,507,569,101	2,498,204,576	7,511,635,894

NOTE: PMPM links to BN Detail_2011 09 08 REDUCED UPL AND MANAGED CARE (UPL FFSE OUT) v2.xlsx.

Month 1 (Jan 2016)	Month 2 (Feb 2016)	Month 3 (Mar 2016)	Total for Quarter Ending 03/2016
279,359	277,179	279,039	835,577
906.18	*906.18*	*906.18*	*906.18*
199.00	*199.00*	*199.00*	*199.00*
0.00	*0.00*	*0.00*	*0.00*
0.00	*0.00*	*0.00*	*0.00*
253,150,445	251,174,532	252,860,266	757,185,242
55,591,852	55,157,941	55,528,129	166,277,922
0	0	0	-
0	0	0	-
2,629,772	2,633,719	2,619,921	7,883,412
316.99	*316.99*	*316.99*	*316.99*
26.69	*26.69*	*26.69*	*26.69*
0.00	*0.00*	*0.00*	*0.00*
0.00	*0.00*	*0.00*	*0.00*
833,620,745	834,871,687	830,497,937	2,498,990,368
70,179,450	70,284,763	69,916,553	210,380,765
0	0	0	-
0	0	0	-
363,450	364,215	362,697	1,090,362
1,140.52	*1,140.52*	*1,140.52*	*1,140.52*
3.63	*3.63*	*3.63*	*3.63*
0.00	*0.00*	*0.00*	*0.00*
0.00	*0.00*	*0.00*	*0.00*
414,520,819	415,392,877	413,662,422	1,243,576,118
1,320,652	1,323,430	1,317,917	3,961,999
0	0	0	-
0	0	0	-
426,481	428,097	427,063	1,281,641
1,538.16	*1,538.16*	*1,538.16*	*1,538.16*
174.29	*174.29*	*174.29*	*174.29*
0.00	*0.00*	*0.00*	*0.00*
0.00	*0.00*	*0.00*	*0.00*
655,997,508	658,484,126	656,892,875	1,971,374,509
74,329,224	74,610,976	74,430,676	223,370,876
0	0	0	-
0	0	0	-
3,699,062	3,703,210	3,688,720	11,090,992
583.20	*583.26*	*583.92*	*583.46*
54.45	*54.38*	*54.54*	*54.46*
0.00	*0.00*	*0.00*	*0.00*
0.00	*0.00*	*0.00*	*0.00*
2,157,289,517	2,159,923,222	2,153,913,499	6,471,126,238
201,421,178	201,377,110	201,193,274	603,991,562
0	0	0	-
0	0	0	-
2,358,710,695	2,361,300,332	2,355,106,773	7,075,117,800

145,084,109 145,084,109 145,084,109 435,252,328

2,503,794,804	2,506,384,441	2,500,190,882	7,510,370,128

Managed Care Hospital Transition 1115 waiver

Quarter Reporting Period

Q2 (Jan 2016 - Mar 2016)

Medicaid Eligibility Group		Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015
Adults	Caseload	283,113	279,896	276,783	839,792
	PMPM	*549.79*	*549.36*	*556.31*	*551.80*
	Cost	155,653,831	153,763,608	153,977,497	463,394,935
Children	Caseload	2,621,652	2,631,172	2,628,503	7,881,326
	PMPM	*236.58*	*235.39*	*238.23*	*236.73*
	Cost	620,229,796	619,354,335	626,179,385	1,865,763,515
AMR (non-MRSA)	Caseload	364,111	364,377	361,407	1,089,896
	PMPM	*985.93*	*983.25*	*994.37*	*987.83*
	Cost	358,987,092	358,273,879	359,373,645	1,076,634,616
Disability-Related	Caseload	426,453	427,438	426,498	1,280,390
	PMPM	*1,445.65*	*1,425.13*	*1,451.43*	*1,440.73*
	Cost	616,501,499	609,157,279	619,032,071	1,844,690,849
Total Medical: without Pool	Caseload	3,695,329	3,702,883	3,693,192	11,091,404
	PMPM	*473.94*	*470.05*	*476.16*	*473.38*
	Cost	1,751,372,217	1,740,549,101	1,758,562,597	5,250,483,916
Waiver Pool	UC	545,023,015	546,137,074	544,707,717	1,635,867,806
	UC UPL	-	-	-	-
	DSRIP	(16,268)	(16,302)	(16,259)	(48,829)
	Total Pool	545,006,747	546,120,773	544,691,458	1,635,818,977
Network Access Improvement Project	NAIP	42,751,614	42,870,450	42,878,597	128,500,660
	NF Dir Pymt	46,522,479	46,576,989	46,947,514	140,046,983

With Waiver Grand Total (including Pool)	2,385,653,058	2,376,117,312	2,393,080,166	7,154,850,536

Month 1 (Jan 2016)	Month 2 (Feb 2016)	Month 3 (Mar 2016)	Total for Quarter Ending 03/2016
279,359	277,179	279,039	835,577
561.11	*560.16*	*563.42*	*561.56*
156,750,514	155,263,886	157,215,301	469,229,702
2,629,772	2,633,719	2,619,921	7,883,412
237.69	*235.26*	*235.20*	*236.05*
625,066,205	619,605,247	616,216,268	1,860,887,720
363,450	364,215	362,697	1,090,362
1,021.03	*989.72*	*986.72*	*999.16*
371,094,047	360,472,125	357,881,383	1,089,447,554
426,481	428,097	427,063	1,281,641
1,431.78	*1,389.88*	*1,417.73*	*1,413.11*
610,626,924	595,005,209	605,460,863	1,811,092,996
3,699,062	3,703,210	3,688,720	11,090,992
476.75	*467.26*	*470.83*	*471.61*
1,763,537,690	1,730,346,467	1,736,773,815	5,230,657,971
481,720,335	482,260,392	480,373,509	1,444,354,236
-	-	-	-
634,238,538	634,949,583	632,465,291	1,901,653,412
1,115,958,874	1,117,209,975	1,112,838,799	3,346,007,648
42,755,842	42,655,040	42,438,726	127,849,607
46,968,749	46,745,712	46,472,803	140,187,264
2,969,221,154	2,936,957,194	2,938,524,143	8,844,702,491

Managed Care Hospital Transition 1115 waiver

Quarter Reporting Period

Q2 (Jan 2016 - Mar 2016)

Cost differences are given are WOW minus WW, so a positive number indicates that the WW is less costly than th

Medicaid Eligibility Group		Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015
Adults	Caseload	283,113	279,896	276,783	839,792
	PMPM	*555.39*	*555.82*	*548.87*	*553.38*
	Cost	157,237,310	155,571,427	151,917,721	464,726,457
Children	Caseload	2,621,652	2,631,172	2,628,503	7,881,326
	PMPM	*107.10*	*108.29*	*105.45*	*106.95*
	Cost	280,779,498	284,926,813	277,184,426	842,890,737
AMR (non-MRSA)	Caseload	364,111	364,377	361,407	1,089,896
	PMPM	*158.22*	*160.90*	*149.78*	*156.32*
	Cost	57,610,432	58,628,212	54,130,693	170,369,338
Disability-Related	Caseload	426,453	427,438	426,498	1,280,390
	PMPM	*266.80*	*287.32*	*261.02*	*271.72*
	Cost	113,778,650	122,809,438	111,325,030	347,913,118
Total Medical: without Pool	Caseload	3,695,329	3,702,883	3,693,192	11,091,404
	PMPM	*164.91*	*167.96*	*160.99*	*164.62*
	Cost	609,405,890	621,935,891	594,557,870	1,825,899,650

WOW: Other UPL Programs	145,084,109	145,084,109	145,084,109	435,252,328
WW: UC/DSRIP Pool	(545,006,747)	(546,120,773)	(544,691,458)	(1,635,818,977)
WW: NAIP/MPAP	(89,274,093)	(89,447,439)	(89,826,111)	(268,547,643)
WW: Dual Demo Savings Removal	(754,132)	(694,910)	(652,959)	(2,102,001)

With Waiver Grand Total Variance (including Pool, NAIP and DD adjustment)	119,455,027	130,756,879	104,471,451	354,683,357

ıe WOW.

Month 1 (Jan 2016)	Month 2 (Feb 2016)	Month 3 (Mar 2016)	Total for Quarter Ending 03/2016
279,359	277,179	279,039	835,577
544.07	*545.02*	*541.76*	*543.62*
151,991,782	151,068,587	151,173,093	454,233,462
2,629,772	2,633,719	2,619,921	7,883,412
105.99	*108.42*	*108.48*	*107.63*
278,733,990	285,551,203	284,198,221	848,483,414
363,450	364,215	362,697	1,090,362
123.12	*154.43*	*157.43*	*144.99*
44,747,424	56,244,183	57,098,956	158,090,562
426,481	428,097	427,063	1,281,641
280.67	*322.57*	*294.72*	*299.34*
119,699,809	138,089,893	125,862,688	383,652,390
3,699,062	3,703,210	3,688,720	11,090,992
160.90	*170.38*	*167.63*	*166.30*
595,173,005	630,953,865	618,332,958	1,844,459,828
145,084,109	145,084,109	145,084,109	435,252,328
(1,115,958,874)	(1,117,209,975)	(1,112,838,799)	(3,346,007,648)
(89,724,591)	(89,400,751)	(88,911,529)	(268,036,871)
(1,603,173)	(1,506,696)	(1,456,821)	(4,566,690)
(467,029,523)	(432,079,448)	(439,790,082)	(1,338,899,053)

Managed Care Hospital Transition 1115 waiver

Quarter Reporting Period

Q2 (Jan 2016 - Mar 2016)

Medicaid Eligibility Group		Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015	Month 1 (Jan 2016)
Adults	Caseload	283,113	279,896	276,783	839,792	279,359
	PMPM	*549.79*	*549.36*	*556.31*	*551.80*	*561.11*
	Cost	155,653,831	153,763,608	153,977,497	463,394,935	156,750,514
Children	Caseload	2,621,652	2,631,172	2,628,503	7,881,326	2,629,772
	PMPM	*236.58*	*235.39*	*238.23*	*236.73*	*237.69*
	Cost	620,229,796	619,354,335	626,179,385	1,865,763,515	625,066,205
AMR	Caseload	364,111	364,377	361,407	1,089,896	363,450
	PMPM	*985.93*	*983.25*	*994.37*	*987.83*	*1,021.03*
	Cost	358,987,092	358,273,879	359,373,645	1,076,634,616	371,094,047
Disabled and Blind	Caseload	426,453	427,438	426,498	1,280,390	426,481
	PMPM	*1,445.65*	*1,425.13*	*1,451.43*	*1,440.73*	*1,431.78*
	Cost	616,501,499	609,157,279	619,032,071	1,844,690,849	610,626,924

Data Source 201512 reports

Month 2 (Feb 2016)	Month 3 (Mar 2016)	Total for Quarter Ending 03/2016
277,179	279,039	835,577
560.16	*563.42*	*561.56*
155,263,886	157,215,301	469,229,702
2,633,719	2,619,921	7,883,412
235.26	*235.20*	*236.05*
619,605,247	616,216,268	1,860,887,720
364,215	362,697	1,090,362
989.72	*986.72*	*999.16*
360,472,125	357,881,383	1,089,447,554
428,097	427,063	1,281,641
1,389.88	*1,417.73*	*1,413.11*
595,005,209	605,460,863	1,811,092,996

1115A Demonstration Month	Medicaid Savings % Applied per MOU	BEXAR SDA			DALLAS SDA			EL
		HCBS	OCC	NF	HCBS	OCC	NF	HCBS
Mar-15	1.25%	1	10	3	-	6	-	-
Apr-15	1.25%	13	1,800	19	16	1,920	11	13
May-15	1.25%	248	3,501	25	171	3,567	28	124
Jun-15	1.25%	446	4,996	41	362	4,819	36	278
Jul-15	1.25%	556	6,155	51	452	6,044	46	380
Aug-15	1.25%	906	7,881	1,411	503	6,989	56	631
Sep-15	1.25%	810	7,482	1,349	678	6,867	72	578
Oct-15	1.25%	772	7,143	1,281	552	6,576	1,587	557
Nov-15	1.25%	726	6,774	1,123	490	6,101	1,453	519
Dec-15	1.25%	710	6,446	1,048	456	5,649	1,353	513
Jan-16	2.75%	785	7,027	1,203	548	6,421	1,495	543
Feb-16	2.75%	734	6,742	1,127	484	5,955	1,402	525
Mar-16	2.75%	703	6,625	1,057	463	5,746	1,345	509
Apr-16	2.75%							
May-16	2.75%							
Jun-16	2.75%							

For purposes of 1115(a) demonstration budget neutrality reporting, the State reports the following information for
Number of Medicare-Medicaid enrollees served under the 1115A duals demonstration= This number is not yet av
Number of member months = 149,501
PMPM Savings per dual beneficiary enrolled in the 1115A duals demonstration = $30.62

For purposes of 1115(a) demonstration budget neutrality reporting, the State reports the following information for
For purposes of 1115(a) demonstration budget neutrality reporting, the State reports the following information for

Dual Demonstration Recipient Months

PASO SDA		HARRIS SDA			HIDALGO SDA			TARRANT SDA		
OCC	NF	HCBS	OCC	NF	HCBS	OCC	NF	HCBS	OCC	NF
4	-	1	33	-	1	12	1	-	6	-
1,515	9	22	5,302	16	33	2,215	24	6	950	6
2,388	14	361	8,223	33	423	4,119	34	112	1,626	7
3,734	16	580	10,005	47	689	5,711	32	273	2,428	20
4,655	19	731	11,586	61	873	6,741	43	342	3,050	22
5,755	393	980	13,805	75	1,041	7,671	56	357	3,614	32
5,416	381	1,274	13,852	2,241	1,222	7,498	60	417	3,769	38
5,224	379	1,020	12,890	2,068	1,100	7,094	632	364	3,714	1,046
4,979	366	845	11,738	1,911	1,021	6,687	573	337	3,480	977
4,754	347	755	10,787	1,790	975	6,398	540	304	3,245	912
5,147	397	840	12,058	1,956	1,082	7,428	584	346	3,590	1,009
4,932	382	747	11,057	1,850	1,022	7,007	567	310	3,378	944
4,857	374	720	10,766	1,764	989	6,907	548	295	3,294	914

DY5 Quarter 2:

*/*ailable due to a two-quarter time lag required for the data collection process.

DY4 Quarter 3:	40,199
DY4 Quarter 4:	64,059

	Actual Medica							
STATEWIDE TOTAL	BEXAR SDA HCBS	BEXAR SDA OCC	BEXAR SDA NF	DALLAS SDA HCBS	DALLAS SDA OCC	DALLAS SDA NF	EL PASO SD HCBS	EL PASO SD OCC
78	$ 1,918.73	$ 428.35	$ 3,724.49	$ 1,648.51	$ 350.12	$ 3,644.79	$ 2,111.99	$ 504.73
13,890	$ 1,918.73	$ 428.35	$ 3,724.49	$ 1,648.51	$ 350.12	$ 3,644.79	$ 2,111.99	$ 504.73
25,004	$ 1,918.73	$ 428.35	$ 3,724.49	$ 1,648.51	$ 350.12	$ 3,644.79	$ 2,111.99	$ 504.73
34,513	$ 2,002.28	$ 443.52	$ 3,724.49	$ 1,710.29	$ 368.80	$ 3,644.79	$ 2,198.50	$ 515.36
41,807	$ 2,002.28	$ 443.52	$ 3,724.49	$ 1,710.29	$ 368.80	$ 3,644.79	$ 2,198.50	$ 515.36
52,156	$ 2,002.28	$ 443.52	$ 3,724.49	$ 1,710.29	$ 368.80	$ 3,644.79	$ 2,198.50	$ 515.36
54,004	$ 2,008.16	$ 462.07	$ 3,983.91	$ 1,806.30	$ 390.90	$ 3,983.50	$ 2,138.79	$ 547.04
53,999	$ 2,008.16	$ 462.07	$ 3,983.91	$ 1,806.30	$ 390.90	$ 3,983.50	$ 2,138.79	$ 547.04
50,101	$ 2,008.16	$ 462.07	$ 3,983.91	$ 1,806.30	$ 390.90	$ 3,983.50	$ 2,138.79	$ 547.04
46,983	$ 2,008.16	$ 462.07	$ 3,983.91	$ 1,806.30	$ 390.90	$ 3,983.50	$ 2,138.79	$ 547.04
52,458	$ 1,977.67	$ 455.06	$ 3,923.40	$ 1,778.85	$ 384.97	$ 3,923.00	$ 2,106.30	$ 538.74
49,166	$ 1,977.67	$ 455.06	$ 3,923.40	$ 1,778.85	$ 384.97	$ 3,923.00	$ 2,106.30	$ 538.74
47,878	$ 1,977.67	$ 455.06	$ 3,923.40	$ 1,778.85	$ 384.97	$ 3,923.00	$ 2,106.30	$ 538.74
0								
0								
0								

aid Capitation Rate (includes savings)

A	HARRIS SDA			HIDALGO SDA			TARRANT SD	
NF	HCBS	OCC	NF	HCBS	OCC	NF	HCBS	OCC
$ 3,912.87	$ 1,782.70	$ 388.46	$ 3,620.86	$ 2,171.26	$ 1,045.93	$ 4,195.26	$ 1,705.48	$ 282.16
$ 3,912.87	$ 1,782.70	$ 388.46	$ 3,620.86	$ 2,171.26	$ 1,045.93	$ 4,195.26	$ 1,705.48	$ 282.16
$ 3,912.87	$ 1,782.70	$ 388.46	$ 3,620.86	$ 2,171.26	$ 1,045.93	$ 4,195.26	$ 1,705.48	$ 282.16
$ 3,912.87	$ 1,885.96	$ 408.64	$ 3,620.86	$ 2,281.51	$ 1,051.78	$ 4,195.26	$ 1,746.33	$ 315.54
$ 3,912.87	$ 1,885.96	$ 408.64	$ 3,620.86	$ 2,281.51	$ 1,051.78	$ 4,195.26	$ 1,746.33	$ 315.54
$ 3,912.87	$ 1,885.96	$ 408.64	$ 3,620.86	$ 2,281.51	$ 1,051.78	$ 4,195.26	$ 1,746.33	$ 315.54
$ 4,231.99	$ 1,957.50	$ 404.39	$ 3,915.85	$ 2,303.00	$ 1,070.31	$ 4,474.16	$ 1,735.62	$ 323.11
$ 4,231.99	$ 1,957.50	$ 404.39	$ 3,915.85	$ 2,303.00	$ 1,070.31	$ 4,474.16	$ 1,735.62	$ 323.11
$ 4,231.99	$ 1,957.50	$ 404.39	$ 3,915.85	$ 2,303.00	$ 1,070.31	$ 4,474.16	$ 1,735.62	$ 323.11
$ 4,231.99	$ 1,957.50	$ 404.39	$ 3,915.85	$ 2,303.00	$ 1,070.31	$ 4,474.16	$ 1,735.62	$ 323.11
$ 4,167.71	$ 1,927.76	$ 398.25	$ 3,856.37	$ 2,268.01	$ 1,054.05	$ 4,406.19	$ 1,709.28	$ 318.19
$ 4,167.71	$ 1,927.76	$ 398.25	$ 3,856.37	$ 2,268.01	$ 1,054.05	$ 4,406.19	$ 1,709.28	$ 318.19
$ 4,167.71	$ 1,927.76	$ 398.25	$ 3,856.37	$ 2,268.01	$ 1,054.05	$ 4,406.19	$ 1,709.28	$ 318.19

Hypothetical Medicaid Capit

DA	BEXAR SDA			DALLAS SDA			EL PASO SDA		
NF	HCBS	OCC	NF	HCBS	OCC	NF	HCBS	OCC	NF
$ 3,478.64	$ 1,943.02	$ 433.77	$ 3,771.64	$ 1,669.38	$ 354.55	$ 3,690.93	$ 2,138.72	$ 511.12	$ 3,962.40
$ 3,478.64	$ 1,943.02	$ 433.77	$ 3,771.64	$ 1,669.38	$ 354.55	$ 3,690.93	$ 2,138.72	$ 511.12	$ 3,962.40
$ 3,478.64	$ 1,943.02	$ 433.77	$ 3,771.64	$ 1,669.38	$ 354.55	$ 3,690.93	$ 2,138.72	$ 511.12	$ 3,962.40
$ 3,478.64	$ 2,027.63	$ 449.13	$ 3,771.64	$ 1,731.94	$ 373.47	$ 3,690.93	$ 2,226.33	$ 521.88	$ 3,962.40
$ 3,478.64	$ 2,027.63	$ 449.13	$ 3,771.64	$ 1,731.94	$ 373.47	$ 3,690.93	$ 2,226.33	$ 521.88	$ 3,962.40
$ 3,478.64	$ 2,027.63	$ 449.13	$ 3,771.64	$ 1,731.94	$ 373.47	$ 3,690.93	$ 2,226.33	$ 521.88	$ 3,962.40
$ 3,814.99	$ 2,033.58	$ 467.92	$ 4,034.34	$ 1,829.16	$ 395.85	$ 4,033.92	$ 2,165.86	$ 553.96	$ 4,285.56
$ 3,814.99	$ 2,033.58	$ 467.92	$ 4,034.34	$ 1,829.16	$ 395.85	$ 4,033.92	$ 2,165.86	$ 553.96	$ 4,285.56
$ 3,814.99	$ 2,033.58	$ 467.92	$ 4,034.34	$ 1,829.16	$ 395.85	$ 4,033.92	$ 2,165.86	$ 553.96	$ 4,285.56
$ 3,814.99	$ 2,033.58	$ 467.92	$ 4,034.34	$ 1,829.16	$ 395.85	$ 4,033.92	$ 2,165.86	$ 553.96	$ 4,285.56
$ 3,757.04	$ 2,033.59	$ 467.93	$ 4,034.34	$ 1,829.15	$ 395.86	$ 4,033.93	$ 2,165.86	$ 553.97	$ 4,285.56
$ 3,757.04	$ 2,033.59	$ 467.93	$ 4,034.34	$ 1,829.15	$ 395.86	$ 4,033.93	$ 2,165.86	$ 553.97	$ 4,285.56
$ 3,757.04	$ 2,033.59	$ 467.93	$ 4,034.34	$ 1,829.15	$ 395.86	$ 4,033.93	$ 2,165.86	$ 553.97	$ 4,285.56
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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

ation Rate (without savings)									
HARRIS SDA			HIDALGO SDA			TARRANT SDA			E
HCBS	OCC	NF	HCBS	OCC	NF	HCBS	OCC	NF	HCBS
$ 1,805.27	$ 393.38	$ 3,666.69	$ 2,198.74	$ 1,059.17	$ 4,248.36	$ 1,727.07	$ 285.73	$ 3,522.67	$ 24.29
$ 1,805.27	$ 393.38	$ 3,666.69	$ 2,198.74	$ 1,059.17	$ 4,248.36	$ 1,727.07	$ 285.73	$ 3,522.67	$ 24.29
$ 1,805.27	$ 393.38	$ 3,666.69	$ 2,198.74	$ 1,059.17	$ 4,248.36	$ 1,727.07	$ 285.73	$ 3,522.67	$ 24.29
$ 1,909.83	$ 413.81	$ 3,666.69	$ 2,310.39	$ 1,065.09	$ 4,248.36	$ 1,768.44	$ 319.53	$ 3,522.67	$ 25.35
$ 1,909.83	$ 413.81	$ 3,666.69	$ 2,310.39	$ 1,065.09	$ 4,248.36	$ 1,768.44	$ 319.53	$ 3,522.67	$ 25.35
$ 1,909.83	$ 413.81	$ 3,666.69	$ 2,310.39	$ 1,065.09	$ 4,248.36	$ 1,768.44	$ 319.53	$ 3,522.67	$ 25.35
$ 1,982.28	$ 409.51	$ 3,965.42	$ 2,332.15	$ 1,083.86	$ 4,530.79	$ 1,757.59	$ 327.20	$ 3,863.28	$ 25.42
$ 1,982.28	$ 409.51	$ 3,965.42	$ 2,332.15	$ 1,083.86	$ 4,530.79	$ 1,757.59	$ 327.20	$ 3,863.28	$ 25.42
$ 1,982.28	$ 409.51	$ 3,965.42	$ 2,332.15	$ 1,083.86	$ 4,530.79	$ 1,757.59	$ 327.20	$ 3,863.28	$ 25.42
$ 1,982.28	$ 409.51	$ 3,965.42	$ 2,332.15	$ 1,083.86	$ 4,530.79	$ 1,757.59	$ 327.20	$ 3,863.28	$ 25.42
$ 1,982.27	$ 409.51	$ 3,965.42	$ 2,332.14	$ 1,083.86	$ 4,530.79	$ 1,757.61	$ 327.19	$ 3,863.28	$ 55.92
$ 1,982.27	$ 409.51	$ 3,965.42	$ 2,332.14	$ 1,083.86	$ 4,530.79	$ 1,757.61	$ 327.19	$ 3,863.28	$ 55.92
$ 1,982.27	$ 409.51	$ 3,965.42	$ 2,332.14	$ 1,083.86	$ 4,530.79	$ 1,757.61	$ 327.19	$ 3,863.28	$ 55.92
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$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

PMPM Dual Demo Savings

BEXAR SDA		DALLAS SDA			EL PASO SDA			HARRIS SDA	
OCC	NF	HCBS	OCC	NF	HCBS	OCC	NF	HCBS	OCC
$ 5.42	$ 47.15	$ 20.87	$ 4.43	$ 46.14	$ 26.73	$ 6.39	$ 49.53	$ 22.57	$ 4.92
$ 5.42	$ 47.15	$ 20.87	$ 4.43	$ 46.14	$ 26.73	$ 6.39	$ 49.53	$ 22.57	$ 4.92
$ 5.42	$ 47.15	$ 20.87	$ 4.43	$ 46.14	$ 26.73	$ 6.39	$ 49.53	$ 22.57	$ 4.92
$ 5.61	$ 47.15	$ 21.65	$ 4.67	$ 46.14	$ 27.83	$ 6.52	$ 49.53	$ 23.87	$ 5.17
$ 5.61	$ 47.15	$ 21.65	$ 4.67	$ 46.14	$ 27.83	$ 6.52	$ 49.53	$ 23.87	$ 5.17
$ 5.61	$ 47.15	$ 21.65	$ 4.67	$ 46.14	$ 27.83	$ 6.52	$ 49.53	$ 23.87	$ 5.17
$ 5.85	$ 50.43	$ 22.86	$ 4.95	$ 50.42	$ 27.07	$ 6.92	$ 53.57	$ 24.78	$ 5.12
$ 5.85	$ 50.43	$ 22.86	$ 4.95	$ 50.42	$ 27.07	$ 6.92	$ 53.57	$ 24.78	$ 5.12
$ 5.85	$ 50.43	$ 22.86	$ 4.95	$ 50.42	$ 27.07	$ 6.92	$ 53.57	$ 24.78	$ 5.12
$ 5.85	$ 50.43	$ 22.86	$ 4.95	$ 50.42	$ 27.07	$ 6.92	$ 53.57	$ 24.78	$ 5.12
$ 12.87	$ 110.94	$ 50.30	$ 10.89	$ 110.93	$ 59.56	$ 15.23	$ 117.85	$ 54.51	$ 11.26
$ 12.87	$ 110.94	$ 50.30	$ 10.89	$ 110.93	$ 59.56	$ 15.23	$ 117.85	$ 54.51	$ 11.26
$ 12.87	$ 110.94	$ 50.30	$ 10.89	$ 110.93	$ 59.56	$ 15.23	$ 117.85	$ 54.51	$ 11.26
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

A		HIDALGO SDA			TARRANT SDA				E
NF	HCBS	OCC	NF	HCBS	OCC	NF	STATEWIDE	HCBS	
$ 45.83	$ 27.48	$ 13.24	$ 53.10	$ 21.59	$ 3.57	$ 44.03	$ 9.20	24	
$ 45.83	$ 27.48	$ 13.24	$ 53.10	$ 21.59	$ 3.57	$ 44.03	$ 6.72	316	
$ 45.83	$ 27.48	$ 13.24	$ 53.10	$ 21.59	$ 3.57	$ 44.03	$ 7.71	6,023	
$ 45.83	$ 28.88	$ 13.31	$ 53.10	$ 22.11	$ 3.99	$ 44.03	$ 8.35	11,304	
$ 45.83	$ 28.88	$ 13.31	$ 53.10	$ 22.11	$ 3.99	$ 44.03	$ 8.40	14,092	
$ 45.83	$ 28.88	$ 13.31	$ 53.10	$ 22.11	$ 3.99	$ 44.03	$ 9.81	22,963	
$ 49.57	$ 29.15	$ 13.55	$ 56.63	$ 21.97	$ 4.09	$ 48.29	$ 11.84	20,585	
$ 49.57	$ 29.15	$ 13.55	$ 56.63	$ 21.97	$ 4.09	$ 48.29	$ 13.97	19,613	
$ 49.57	$ 29.15	$ 13.55	$ 56.63	$ 21.97	$ 4.09	$ 48.29	$ 13.87	18,463	
$ 49.57	$ 29.15	$ 13.55	$ 56.63	$ 21.97	$ 4.09	$ 48.29	$ 13.90	18,049	
$ 109.05	$ 64.13	$ 29.81	$ 124.60	$ 48.33	$ 9.00	$ 106.24	$ 30.56	43,924	
$ 109.05	$ 64.13	$ 29.81	$ 124.60	$ 48.33	$ 9.00	$ 106.24	$ 30.65	41,070	
$ 109.05	$ 64.13	$ 29.81	$ 124.60	$ 48.33	$ 9.00	$ 106.24	$ 30.43	39,304	
$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	
$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	
$ -	$ -	$ -	$ -	$ -	$ -	$ -		-	

Amount Subtracted from BN Savings/

BEXAR SDA		DALLAS SDA			EL PASO SDA			HARRIS SDA	
OCC	NF	HCBS	OCC	NF	HCBS	OCC	NF	HCBS	OCC
54	141	-	27	-	-	26	-	23	162
9,760	896	334	8,509	508	348	9,679	446	496	26,071
18,983	1,179	3,568	15,809	1,292	3,315	15,257	693	8,146	40,434
28,048	1,933	7,837	22,497	1,661	7,736	24,359	792	13,846	51,752
34,555	2,404	9,785	28,216	2,122	10,575	30,367	941	17,451	59,930
44,245	66,522	10,890	32,627	2,584	17,560	37,543	19,465	23,395	71,409
43,760	68,009	15,509	33,980	3,639	15,643	37,501	20,424	31,575	70,907
41,779	64,576	12,629	32,540	80,001	15,070	36,175	20,327	25,274	65,981
39,618	56,630	11,215	30,189	73,286	14,063	34,477	19,591	20,943	60,084
37,704	52,849	10,424	27,952	68,244	13,899	32,921	18,571	18,701	55,219
90,421	133,467	27,550	69,895	165,794	32,346	78,404	46,797	45,768	135,797
86,762	124,987	24,340	64,823	155,572	31,253	75,138	45,035	40,748	124,519
85,256	117,264	23,282	62,550	149,153	30,312	73,993	44,131	39,255	121,243
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-

Margin								Quarterly Total
A	HIDALGO SDA			TARRANT SDA			STATEWIDE	
NF	HCBS	OCC	NF	HCBS	OCC	NF	TOTAL	
-	27	159	53	-	21	-	718	718
733	907	29,326	1,275	130	3,393	264	93,390	
1,513	11,626	54,534	1,806	2,418	5,807	308	192,711	574,267
2,154	19,898	76,034	1,699	6,035	9,698	881	288,166	
2,796	25,212	89,747	2,283	7,560	12,182	969	351,190	
3,438	30,064	102,129	2,974	7,892	14,435	1,409	511,543	1,502,371
111,062	35,629	101,584	3,412	9,165	15,416	1,837	639,638	
102,511	32,069	96,116	35,780	8,004	15,191	50,497	754,132	
94,709	29,759	90,601	32,444	7,409	14,233	47,197	694,910	2,102,001
88,730	28,437	86,677	30,561	6,686	13,270	44,064	652,959	
213,300	69,365	221,414	72,754	16,713	32,306	107,160	1,603,173	
201,714	65,522	208,853	70,670	14,987	30,392	100,311	1,506,696	4,566,690
192,396	63,449	205,873	68,303	14,274	29,638	97,145	1,456,821	
-	-	-	-	-	-	-	-	
-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	