Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly Report for

Managed Care

Texas Health and Human Services Commission

Demonstration Reporting Period:

2017 State Fiscal Quarter 3, March 2017 - May 2017

Demonstration Year (DY) 6 Quarter 3, April 2017 - June 2017

Contents

I. Introduction 3
A. Manged Care Plans Participating in the Waiver Program 3
B. Monitoring Managed Care Plans 3
II. Enrollment and Benefits Information 4
A. Eligibility and Enrollment 4
B. Enrollment Counts for the Quarter by Population 16
C. Medicaid Eligibility Changes 16
D. Anticipated Changes in Populations or Benefits 16
III. Delivery Networks and Access 17
A. Provider Networks 17
B. GeoAccess 18
C. Out-of-Network Utilization 21
IV. Outreach/Innovative Activities to Assure Access 22
A. Enrollment Broker and Plan Activities 22
B. Dental Stakeholder Meeting 23
C. Medicaid Managed Care Advisory Committee 23
D. Public Forum 23
E. Independent Consumer Supports System Plan 24
F. HHSC Managed Care Initiatives 25
V. Collection and Verification of Encounter Data and Enrollment Data. 27
VI. Action Plans for Addressing Any Issues Identified 27
VII. Consumer Issues 27
A. Hotline Call Volume and Performance 27
B. Complaints and Appeals Received by Plans 29
C. Complaints Received by the State 38
VIII. QUALITY Assurance/Monitoring Activity 41
A. DY6Q3 Quarter 3 Update 41
Enclosures/Attachments 43
State Contacts 44
Acronym list 45

I. INTRODUCTION

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

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- 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 STAR, STAR+PLUS, and STAR Kids 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, 21, 23, 40(a), and 70. These STCs require the State to report on various topics, including: enrollments; anticipated changes in populations or benefits; network adequacy; encounter data; operational, policy, systems, and fiscal issues; action plans for addressing identified issues; consumer issues; and quality assurance and monitoring.

The State collects performance and other data from its managed care organizations (or "plans") on a State Fiscal Quarter (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2017 SFQ3 (March 2017 - May 2017) instead of Demonstration Year (DY) 6, Q3 ("2017 DY6Q3," covering April 2017 - June 2017). Throughout the report, the State has identified whether the quarterly data relates to 2017 SFQ3 or 2017 DY6Q3.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2017 SFQ3, the State contracted with 18 STAR, 5 STAR+PLUS, 10 STAR Kids and 2 Dental program plans. Each health plan covers one or more of the 13 service delivery areas (SDAs), for the STAR, STAR+PLUS, and STAR Kids programs while each dental plan provides statewide services. Please refer to Attachment A for a list of the STAR, STAR+PLUS, STAR Kids and Dental plans by area.

B. MONITORING MANAGED CARE PLANS

The Health and Human Services Commission (HHSC) staff evaluates and routinely monitors managed care organizations (MCOs) and dental maintenance organizations (DMOs) performance reported by the MCOs and DMOs and compiled by HHSC. If an MCO or DMO fails to meet a performance expectation, standard, schedule, or other contract requirement such as the timely submission of deliverables or 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 (LDs)),
- Corrective action plans (CAPs).

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

II. ENROLLMENT AND BENEFITS INFORMATION

This section addresses STCs 40(a) and 70 including quarterly trends and issues related to STAR, STAR+PLUS, STAR Kids, 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 2017 SFQ3 reporting period (March 2017 - May 2017) instead of 2017 DY2 (January 2017 - March 2017). Supporting data are located in Attachment B.

A. ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 70. Attachment B includes enrollment summaries for the four managed care programs. The enrollment data in this subsection are based on prospective managed care enrollment counts in the last month of the quarter and represent a snapshot of the number of members enrolled in Texas Medicaid managed care programs and health plans. The total enrollment in Texas Medicaid managed care programs, STAR, STAR+PLUS, STAR Kids and Dental, remained relatively the same with a slight decrease of -1.2% from 6,525,699 in 2017 SFQ2 to 6,452,705 in 2017 SFQ3.

1. STAR

The number of members enrolled in STAR decreased by -1.04% from 2,909,684 in 2017 SFQ2 to 2,879,362 in 2017 SFQ3. Across the STAR program, 16 of the 18 MCOs reported enrollment decreases. The largest decline in member enrollments were reported for the MCO Christus at -6.04% and for the Travis SDA at -2.14%. Although few MCOs or SDAs reported increases this quarter, the majority of MCOs and SDAs experienced enrollment changes of less than 3%.

Enrollment by STAR MCO (2017 SFQ2- 2017 SFQ3)

Managed Care Organization	17Q2	17Q3	Total Change	Percent Change from SFQ1 2017 to SFQ2 2017
Statewide	**2,909,684**	**2,879,362**	**-30,322**	**-1.04%**
Aetna	70,725	70,116	-609	**-0.86%**
Amerigroup	562,190	549,286	-12,904	**-2.30%**
BCBS	24,927	24,799	-128	**-0.51%**
CHC	240,431	237,994	-2,437	**-1.01%**
Christus	5,411	5,084	-327	**-6.04%**
Community 1st	104,105	102,192	-1,913	**-1.84%**
Cook Children's	101,259	101,115	-144	**-0.14%**

Driscoll	147,448	146,866	-582	**-0.39%**
El Paso 1st	65,167	64,165	-1,002	**-1.54%**
FirstCare	90,579	88,272	-2,307	**-2.55%**
Molina	96,562	95,633	-929	**-0.96%**
Parkland	164,592	160,826	-3,766	**-2.29%**
Scott & White	44,301	43,867	-434	**-0.98%**
Sendero	13,402	12,795	-607	**-4.53%**
Seton	17,982	17,758	-224	**-1.25%**
Superior	699,456	693,926	-5,530	**-0.79%**
Texas Children's	335,836	338,704	2,868	**0.85%**
United	125,311	125,964	653	**0.52%**

Enrollment by STAR SDA (2017 SFQ2– 2017 SFQ3)

STAR - SDA	17Q2	17Q3	Total Change	Percent Change from SFQ1 2017 to SFQ2 2017
Statewide	2,909,684	2879362	-30,322	-1.04%
Bexar	245,397	243,388	-2,009	-0.82%
Dallas	390,042	383,023	-7,019	-1.80%
El Paso	121,660	120,166	-1,494	-1.23%
Harris	693,728	692,037	-1,691	-0.24%
Hidalgo	353,857	348,395	-5,462	-1.54%
Jefferson	75,083	75,118	35	0.05%
Lubbock	75,033	73,932	-1,101	-1.47%
MRSA Central	132,616	131,540	-1,076	-0.81%
MRSA Northeast	169,349	167,332	-2,017	-1.19%
MRSA West	156,326	154,871	-1,455	-0.93%
Nueces	87,648	87,000	-648	-0.74%
Tarrant	265,609	262,298	-3,311	-1.25%
Travis	143,336	140,262	-3,074	-2.14%

Market Share by STAR MCO (2016 -2017)

The STAR market share distribution by MCOs fluctuated slightly from the prior quarter. Amerigroup's percentage point change of -.24% was the highest change between 2017 SFQ2 to 2017 SFQ3. Superior and Amerigroup continue to dominate market share controlling 24.1% and 19.08% of the market respectively.

STAR - MCO	2016 Q4	2017 Q1	2017 Q2	2017 Q3	Percentage Point Change from SFQ2 2017 to SFQ3 2017
Aetna	2.45%	2.43%	2.43%	2.44%	0.01%
Amerigroup	19.42%	19.52%	19.32%	19.08%	-0.24%
BCBS	0.84%	0.83%	0.86%	0.86%	0.00%
CHC	8.23%	8.29%	8.26%	8.27%	0.01%
Christus	0.20%	0.19%	0.19%	0.18%	-0.01%
Community 1st	3.69%	3.63%	3.58%	3.55%	-0.03%
Cook Children's	3.43%	3.46%	3.48%	3.51%	0.03%
Driscoll	4.97%	5.01%	5.07%	5.10%	0.03%

El Paso 1st	2.39%	2.28%	2.24%	2.23%	-0.01%
FirstCare	3.28%	3.18%	3.11%	3.07%	-0.04%
Molina	3.41%	3.36%	3.32%	3.32%	0.00%
Parkland	5.78%	5.72%	5.66%	5.59%	-0.07%
Scott & White	1.51%	1.45%	1.52%	1.52%	0.00%
Sendero	0.45%	0.45%	0.46%	0.44%	-0.02%
Seton	0.63%	0.62%	0.62%	0.62%	0.00%
Superior	23.97%	23.96%	24.04%	24.10%	0.06%
Texas Children's	11.64%	11.50%	11.54%	11.76%	0.22%
United	4.18%	4.12%	4.31%	4.37%	0.06%

2. STAR+PLUS

The number of members enrolled in STAR+PLUS slightly increased at .49% from 519,105 in 2017 SFQ2 to 521,638 in 2017 SFQ3. Most of the STAR+PLUS plans and SDAs reported slight increases in enrollment with the highest MCO increase for Molina at .90% and SDA increase for Harris at 2.14%. Cigna-HealthSpring was the only MCO with a decline in enrollment while several SDAs experienced declines - Jefferson, Lubbock, MRSA Central, MRSA Northeast, MRSA West, Nueces, and Travis.

Enrollment by STAR+PLUS MCO (2017 SFQ2– 2017 SFQ3)

STAR+PLUS -MCO	17Q2	17Q3	Total Change	Percentage Change from SFQ2 2017 to SFQ3 2017
Statewide	519,105	521,638	2533	0.49%
Amerigroup	131953	132914	961	0.73%
Cigna-HealthSpring	50294	49867	-427	-0.85%
Molina	85853	86624	771	0.90%
Superior	137840	138013	173	0.13%
United	113165	114220	1055	0.93%

Enrollment by STAR+PLUS SDA (2017 SFQ2– 2017 SFQ3)

STAR+PLUS	2017 Q2	2017 Q3	Total Change	Percentage Change from SFQ2 2017 to SFQ3 2017
Statewide	**519,105**	**521,638**	**2,533**	**0.49%**
Bexar	44,681	45,030	349	0.78%
Dallas	60,713	61,280	567	0.93%
El Paso	20,080	20,388	308	1.53%
Harris	98,485	100,592	2,107	2.14%
Hidalgo	63,802	63,985	183	0.29%
Jefferson	19,733	19,591	-142	-0.72%
Lubbock	13,275	13,262	-13	-0.10%

MRSA Central	29,513	29,374	-139	-0.47%
MRSA Northeast	45,775	45,296	-479	-1.05%
MRSA West	37,482	37,175	-307	-0.82%
Nueces	21,353	21,210	-143	-0.67%
Tarrant	38,852	39,334	482	1.24%
Travis	25,361	25,121	-240	-0.95%

The STAR+PLUS market share distribution remained relatively stable with only slight changes from 2017 SFQ2 to 2017 SFQ3. Amerigroup, Superior and United MCOs each continued to support approximately one quarter of the market. Superior's minor decrease in market share of -.54% was the only decrease among STAR+PLUS MCOs.

Market Share by STAR+PLUS MCO (2017 SFQ2– 2017 SFQ3)

S+P	2016 Q4	2017Q1	2017Q2	2017Q3	Percentage Point Change from 2017 Q2 to 2017 Q3
Amerigroup	26%	26%	25%	25.48%	1.00%
Cigna-HealthSpring	9%	9%	10%	9.56%	1.00%
Molina	17%	17%	17%	16.61%	0.07%
Superior	27%	26%	26%	26.46%	-.54%
United	21%	22%	22%	21.90%	0.10%

3. STAR Kids

The number of members enrolled in STAR Kids decreased by -1.63% from 2017 SFQ2 to 2017SQ3 as SDAs and MCOs continue to initiate services for the program which began implementation November 1, 2016. Among MCOs, Superior experienced the sharpest change in enrollment at -6.01%. The dip in Superior numbers are highly likely linked to the dip in El Paso numbers. Superior EL Paso SDA had a major decrease in program enrollment among MCOs at a loss of -1,510 members (-30.38%). Numbers will be better understood as more STAR Kids data is gathered and compared in future reporting. STAR Kids numbers for Q1 and Q2 have been updated to reflect latent information and atone for any issues in data entry.

Enrollment by STAR Kids MCO (2017 SFQ2– 2017 SFQ3)

STAR Kids - MCO	17Q2	17Q3	Total Change	Percent Change from SFQ2 2017 to SFQ3 2017
Statewide	**165,141**	**162,444**	**-2,697**	**-1.63%**
Aetna	5,366	5,159	-207	-3.86%
Amerigroup	28,372	27,865	-507	-1.79%
BCBS	7,924	7,810	-114	-1.44%
Children's Medical Center	9,725	9,580	-145	-1.49%
Community 1st	8,170	7,924	-246	-3.01%
Cook Children's	8,728	8,820	92	1.05%
Driscoll	10,728	10,600	-128	-1.19%

Superior	31,045	29,179	-1,866	-6.01%
Texas Children's	24,985	25,410	425	1.70%
United	30,098	30,097	-1	0.00%

Enrollment by STAR Kids SDA (2017 SFQ2– 2017 SFQ3)

STAR Kids - SDA	17Q2	17Q3	Total Change	Percent Change from SFQ2 2017 to SFQ3 2017
Statewide	**165,141**	**162,444**	**-2,697**	**-1.63%**
Bexar	15,453	14,961	-492	-3.18%
Dallas	21,685	21,561	-124	-0.57%
El Paso	6,509	4,924	-1,585	-24.35%
Harris	36,994	36,965	-29	-0.08%
Hidalgo	22,420	22,276	-144	-0.64%
Jefferson	4,972	4,954	-18	-0.36%
Lubbock	3,237	3,308	71	2.19%
MRSA Central	8,702	8,628	-74	-0.85%
MRSA Northeast	10,953	10,954	1	0.01%
MRSA West	6,985	6,957	-28	-0.40%
Nueces	5,613	5,522	-91	-1.62%
Tarrant	14,094	13,979	-115	-0.82%
Travis	7,524	7,455	-69	-0.92%

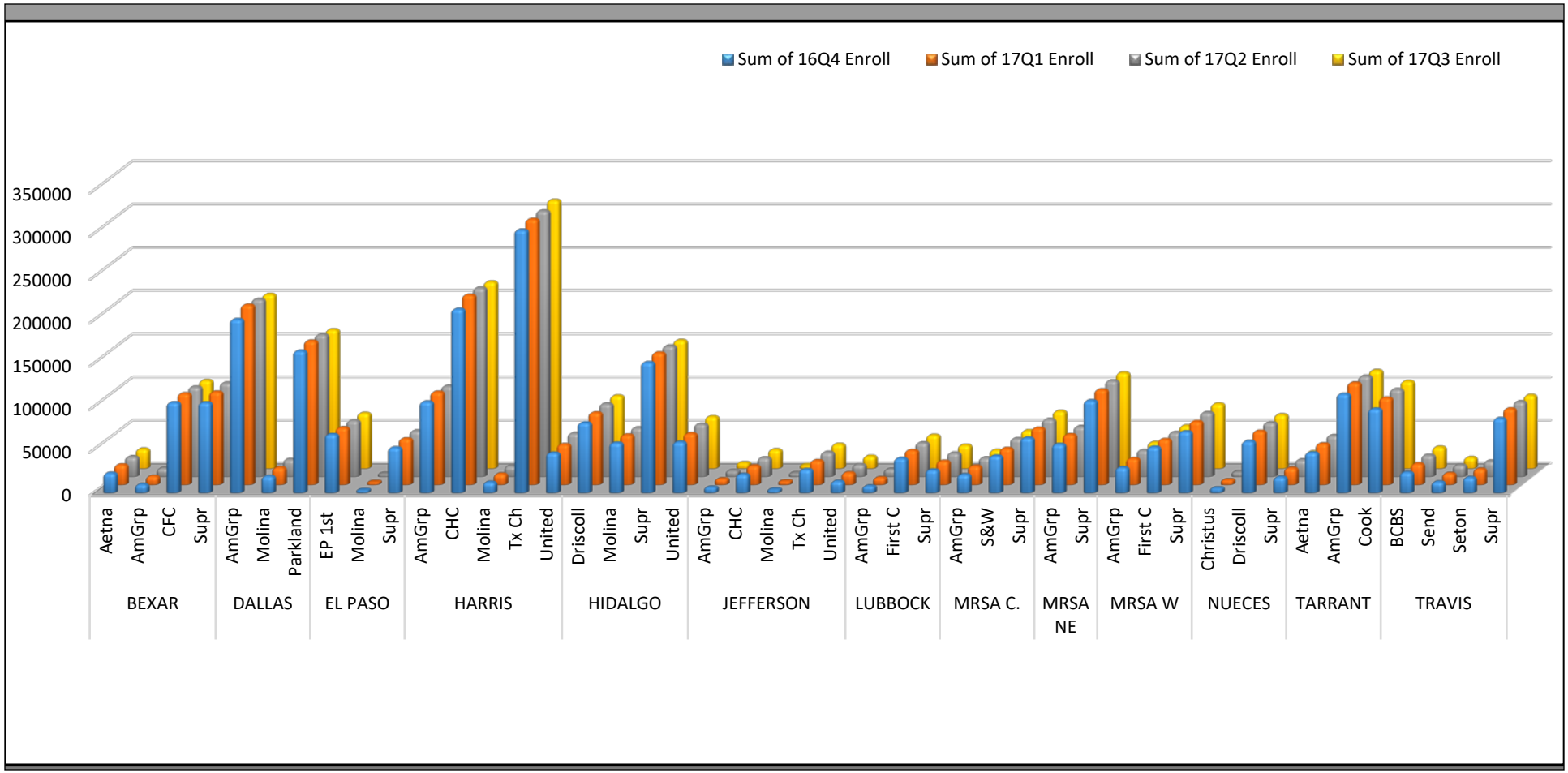
With the exception of Superior, market share differences per STAR Kids MCOs between the second and third quarters of SF2017 did not exceed 6 percentages points. Texas Children's experienced a market share decrease of -1.03% which was the sharpest change among market shares this quarter. Approximately 45% of STAR Kids market was comprised of Texas Children's and Children's Medical Center enrollees.

Market share by STAR Kids MCO (2017 SFQ2– 2017 SFQ3)

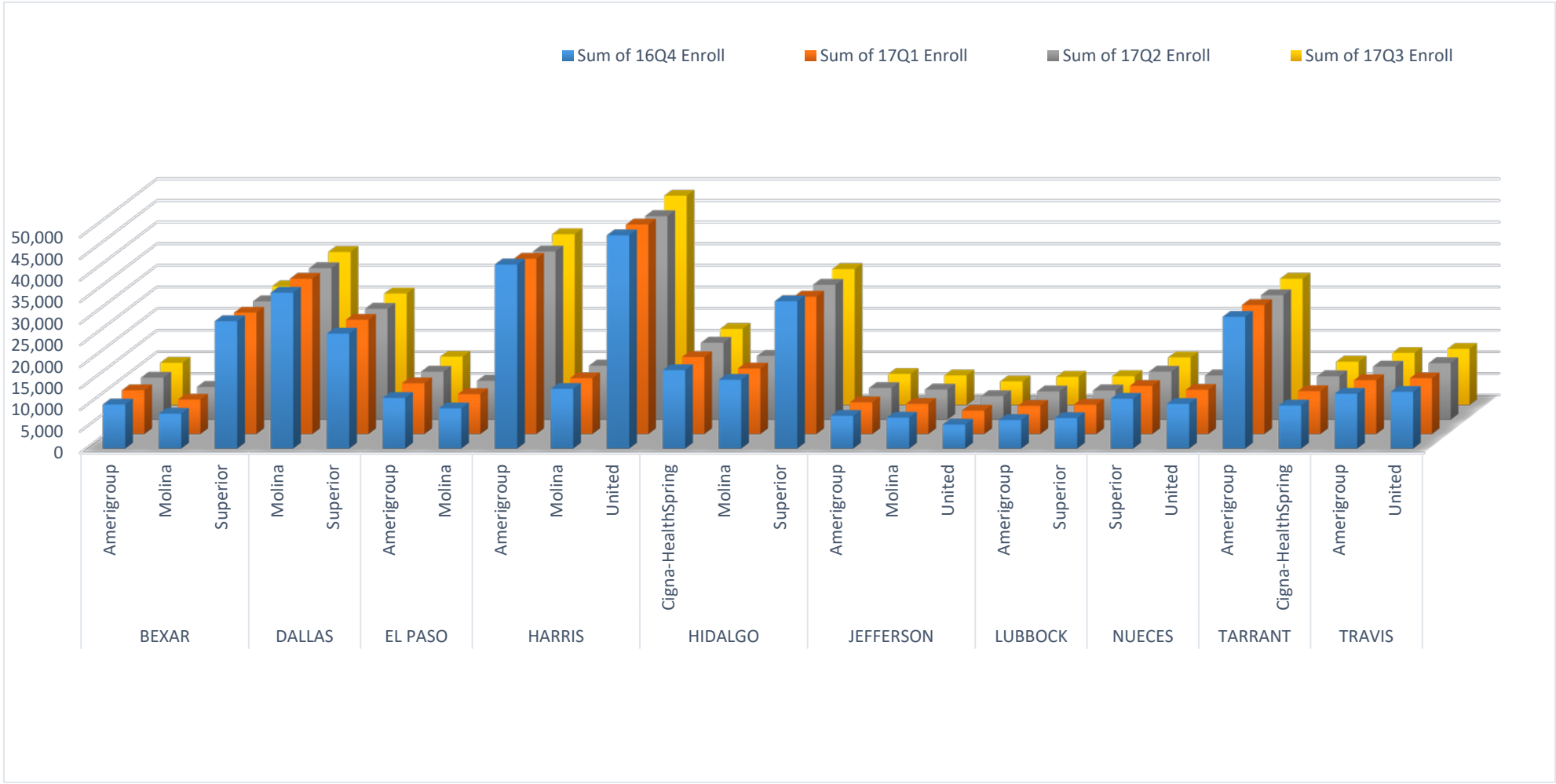
STAR Kids - MCO	2017Q1	2017Q2	2017Q3	Percent Point Change from SFQ1 2017 to SFQ2 2017
Aetna	**4.18%**	**4.02%**	**3.93%**	-0.09%
Amerigroup	**9.06%**	**8.96%**	**9.12%**	0.17%
BCBS	**3.25%**	**3.16%**	**3.17%**	0.01%
Children's Medical Center	**22.93%**	**22.54%**	**22.92%**	0.38%
Community 1st	**3.25%**	**3.16%**	**3.17%**	0.01%
Driscoll	**6.25%**	**6.12%**	**6.03%**	-0.08%
Superior	**8.40%**	**8.03%**	**8.07%**	0.04%
Texas Children's	**22.22%**	**23.25%**	**22.22%**	-1.03%
United	**16.41%**	**16.63%**	**17.23%**	0.60%

The two following graphs illustrate STAR and STAR+PLUS quarterly enrollment by MCO and SDA from SF16Q3 to SF17Q3. The third graph illustrates STAR+PLUS quarterly enrollment in the MRSA SDAs by MCO since the program has been expanded to the MRSA SDAs. The fourth graph shows program enrollment by MCO and SDA from SFQ2 to SFQ3. The fifth graph shows the STAR Kids program enrollment by MCO and SDA for 2017 SFQ2 to SFQ3.

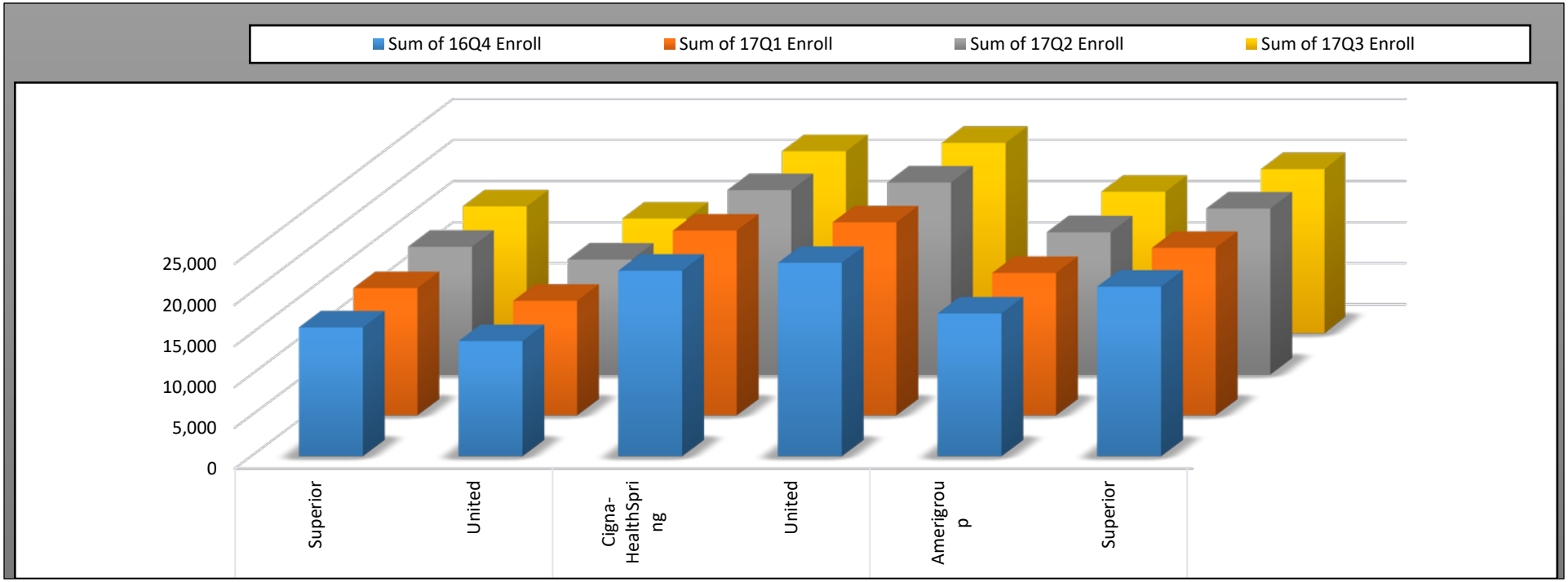
STAR Program Enrollment by MCO and Service Delivery Area (2016 SFQ4-2017 SFQ3)

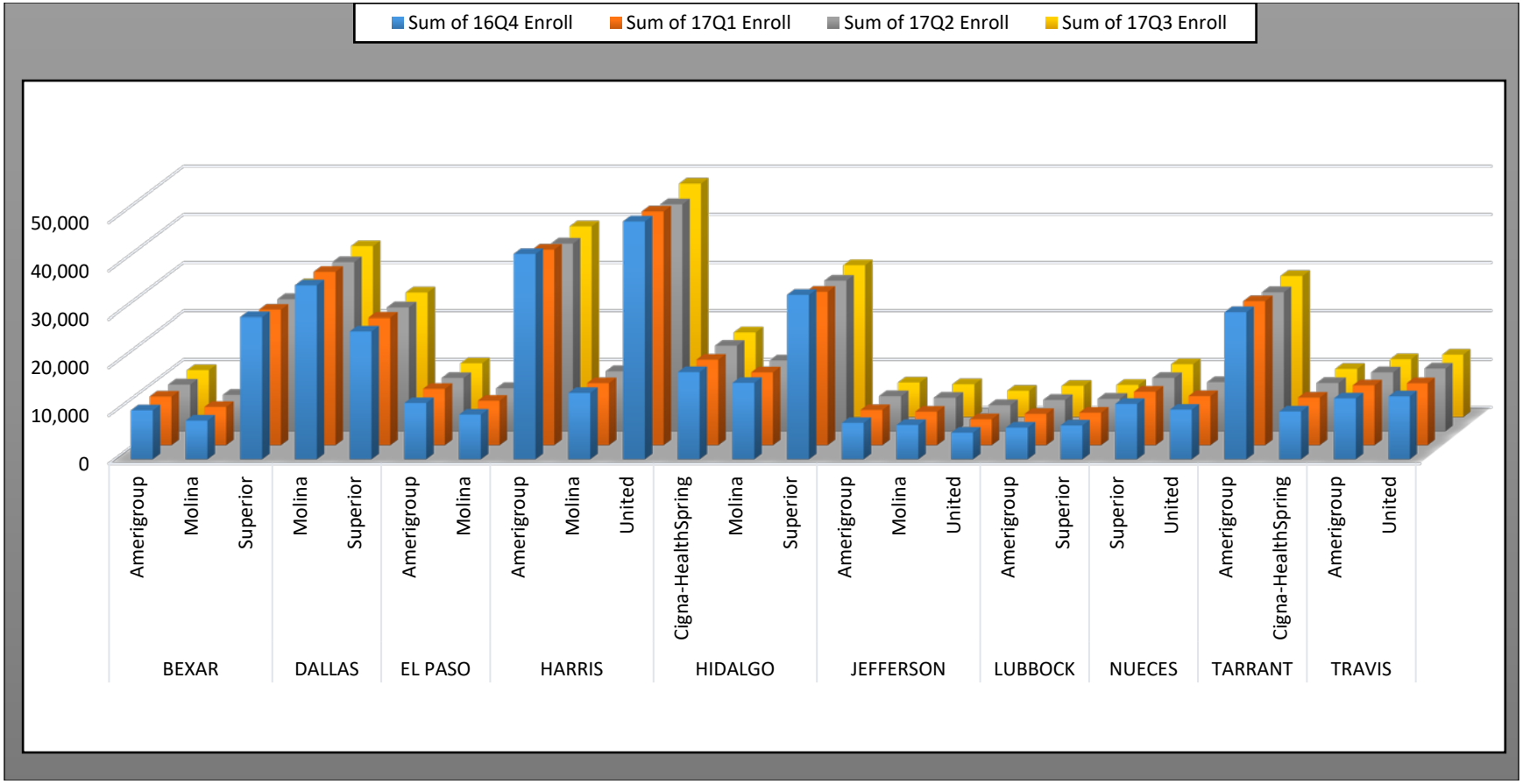


STAR+PLUS Non-MRSA Program Enrollment by MCO and Service Delivery Area (2016 SFQ4-2017 SFQ3)

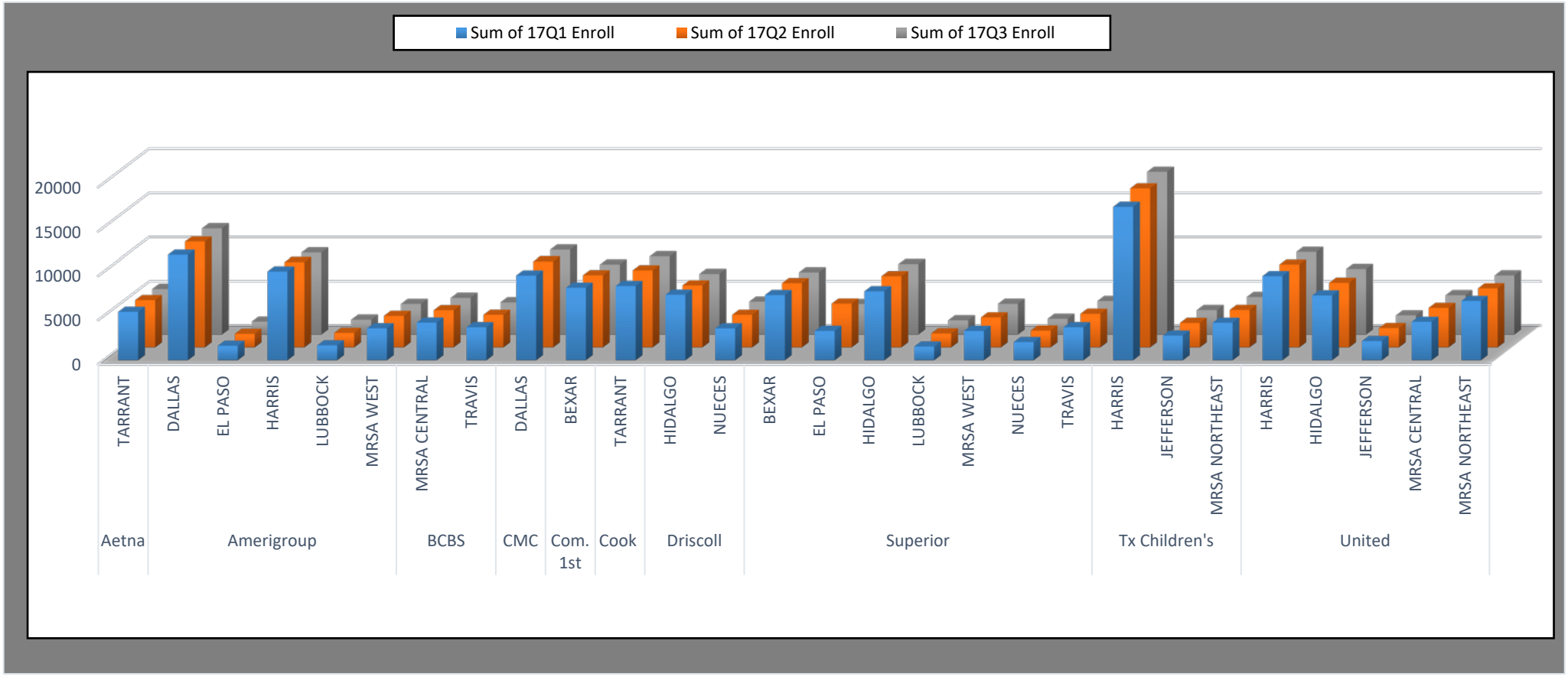


STAR+PLUS MRSA Program Enrollment by MCO and Service Delivery Area (2016 SFQ3-2017 SFQ3)




Sum of 16Q4 Enroll
Sum of 17Q1 Enroll
Sum of 17Q2 Enroll
Sum of 17Q3 Enroll
50,000
40,000
30,000
20,000
10,000
0
Amerigroup
Molina
Superior
Molina
Superior
Amerigroup
Molina
Amerigroup
Molina
United
Cigna-HealthSpring
Molina
Superior
Amerigroup
Molina
United
Amerigroup
Superior
Superior
United
Amerigroup
Cigna-HealthSpring
Amerigroup
United
BEXAR
DALLAS
EL PASO
HARRIS
HIDALGO
JEFFERSON
LUBBOCK
NUECES
TARRANT
TRAVIS

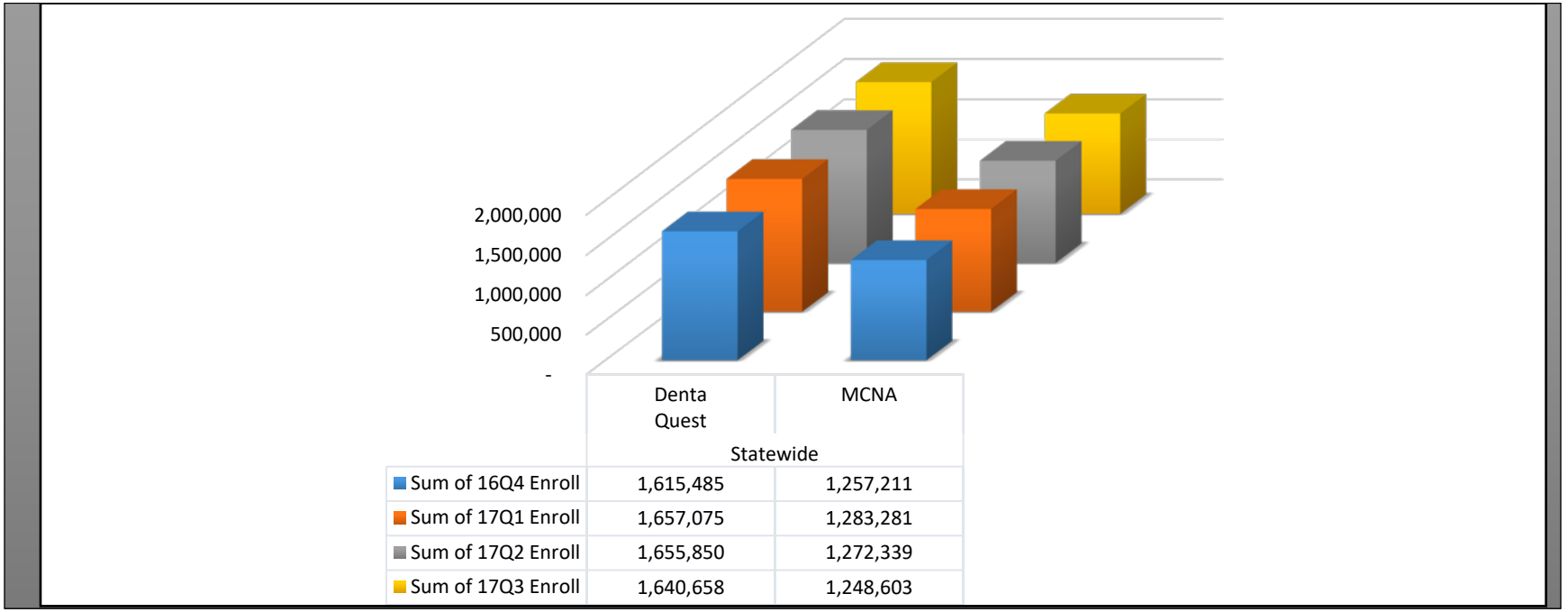
STAR Kids Program Enrollment by MCO and Service Delivery Area (2017 SFQ2-2017 SFQ3)



3. Dental Program

Total enrollment in the Dental Program decreased by -1.33% from 2,928,189 members in 2017 SFQ2 to 2,889,261 members in 2017 SFQ3. Enrollment numbers for both MCNA and DentaQuest have remained relatively stable from SFQ3 2016 to SFQ3 2017. Market shares for the dental program maintained the relatively even distribution obtained in the previous three quarters. The -.54% enrollment decrease for MCNA was negligible as was the .42% increase in enrollment for DentaQuest.

Dental Program Enrollment Statewide (2016 SFQ3 -2017 SFQ3)



	Denta Quest	MCNA
	Statewide	
Sum of 16Q4 Enroll	1,615,485	1,257,211
Sum of 17Q1 Enroll	1,657,075	1,283,281
Sum of 17Q2 Enroll	1,655,850	1,272,339
Sum of 17Q3 Enroll	1,640,658	1,248,603

Dental Market Share Statewide (2016 SFQ4 - 2017 SFQ3)

Dental	2016 Q4	2017Q1	2017Q2	2017Q3	Percentage Point Change from 2017 Q1 to 2017 Q3
DentaQuest	56.07%	56.36%	56.55%	56.78%	0.42%
MCNA	43.64%	43.64%	43.45%	43.22%	-0.54%

B. ENROLLMENT COUNTS FOR THE QUARTER BY POPULATION

This subsection includes quarterly enrollment counts as required by STC 70. Due to the time required for the data collection process, unique member counts per quarter are reported on a two- quarter lag. The following table includes enrollment counts for the 2017 DY6Q3. Enrollment counts are based on persons and not member months.

Enrollment Counts (DY6 Q1 Oct - Dec. 2016)

Demonstration Populations	Total Number Served
Adults	336,584
Children	2,829,438
Aged and Medicare Related (AMR)	383,825
Disabled	433,659

C. MEDICAID ELIGIBILITY CHANGES

No eligibility changes were made to the 1115 waiver populations in 2017 DY6Q3.

D. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

Medicaid Breast and Cervical Cancer, Adoption Assistance/Permanency Care Assistance

Starting September 1, 2017, Medicaid services for approximately 4,800 individuals in the Medicaid for Breast and Cervical Cancer (MBCC) program and for approximately 51,000 individuals in Adoption Assistance and Permanency Care Assistance (AAPCA) program will transition from Medicaid fee-for-service (FFS) to Medicaid managed care.

MBCC clients will be delivered through STAR+PLUS, and AAPCA clients will be delivered through STAR and STAR Kids. Clients in AAPCA who are dually eligible (receive Medicare) and those who receive supplemental security income (SSI) will be enrolled in STAR Kids. All other clients with AAPCA will be enrolled in STAR.

The transition of MBCC to STAR+PLUS will provide clients with unlimited prescriptions, service coordination and access to long term services and supports as needed (services not available in Medicaid FFS). The transition of AAPCA to STAR will provide clients access to enhanced service management and the transition of AAPCA to STAR Kids Medicaid managed care will provide clients with service coordination (services not available in Medicaid FFS).

Service Coordination, Relocation Functions

Effective September 1, 2017, managed care organizations as part of service coordination are contractually responsible for relocation services delivered to members in nursing facilities who wish to receive services in the community. Relocation functions include education and outreach about community options, assessments, transition planning, assistance with community supports such as housing, and follow-up

after the relocation. Members who need assistance with relocation expenses that cannot be met by other resources including Transition Assistance Services (TAS) or community and charitable organizations may also receive one-time financial assistance to help them move. MCOs will review MDS 3.0 referrals and designate a point of contact, if not the MCO, as the Local Contact Agency to respond to referrals from nursing facility members who want to return to the community. MCOs will contract with the community-based organizations that have historically provided relocation services. Previously, relocation services were delivered by community-based organizations under contract with HHSC.

III. DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly reporting requirements found in STCs 40(a) and 70. Supporting data is located in Attachments C through K. HHSC routinely reviews various measures related to network adequacy, including those reported in the following sections of this report: provider network counts, geo-access and out-of-network utilization. HHSC monitors these measures in combination with member complaints in order to assess the adequacy of MCO provider networks. As discussed during the December 2016 monthly monitoring call and in the Q2 report, HHSC continues to focus its efforts to address the new access requirements, Senate Bill (S.B.) 760 (Tex. Leg. Sess. 2015) and 42 §CFR 438.68. In order to address these new requirements, this section of the report will change. Specifically, this report includes distance and travel time baseline reporting, analyzed by HHSC, for PCPs and main dentists. HHSC is ramping up its reporting for distance and travel time baseline data and in the next report additional specialist for distance and travel time will be reported.

A. PROVIDER NETWORKS

This subsection includes quarterly healthcare and pharmacy provider counts for STAR, STAR Kids 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, and provider termination counts are reported in Attachment C3.

1. Primary Care Providers (PCPs)

MCOs are required to assign 100% of non-dual members to a PCP within 5 business days of MCO enrollment. The managed care contracts require all MCOs to assign members to a PCP, and for all adult and child members to have access to a choice of age-appropriate Network PCPs within established mileage standards.

The provider network counts in Attachment C2 show that across the STAR program statewide, the MCOs reported a total of 19,938 unique PCP providers, an increase of 267 (1.36%) from the prior quarter at 19,671. The MCOs reported 15,295 unique PCP providers in the STAR+PLUS program statewide, an increase of 346 (2.30%) from the prior quarter at 15,049. There were 14,783 unique PCP providers in the STAR Kids program, an increase of 1.07% from the previous quarter of 14,625 unique providers.

2. Specialists (non-pharmacy)

Across the STAR program statewide, the MCOs reported 57,735 unique specialty providers, an increase of 133 (.23%) from the prior quarter at 57,602. There was a .29% increase in the number of STAR+PLUS specialists from SFQ2 at 50,537 to SFQ3 at 50,685. The number of STAR Kids specialists decreased by

-4.17% from 44,584 in SFQ2 to 42,727 in SFQ3. The number of specialists reported in the second quarter reflected Travis county numbers so that numbers significantly differ from reporting in the present report. HHSC internal mechanisms for STAR Kids reporting allow for staff to make corrections in the first year.

3. Provider Terminations

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in 2017 SFQ3. The MCOs reported a variety of reasons for provider termination, including: providers failed to re-credential, termination requested by provider, MCO terminated for cause, provider left group practice, provider retired and provider closed practice.

4. Pharmacy Providers

Across the STAR program statewide, the MCOs reported a total of 4,904 unique pharmacies, an increase of 6 (.12%) pharmacies from the prior quarter of 4,898 pharmacies. The MCOs reported 4779 unique pharmacies in the STAR+PLUS program statewide, an increase of 8 (.17%) pharmacies from the prior quarter of 4771 pharmacies. STAR Kids pharmacy data has been updated to reveal that there were 4,873 pharmacies reported by STAR Kids MCOs in Q2 and 4,834 reported for Q3, a decrease of -39 (-.8%). All MCOs contract with the pharmacies outside their primary SDA to ensure members have access to a pharmacy if they travel outside the SDA.

5. Dental Program Provider Counts

In 2017 SFQ3, DentaQuest reported a total of 5,543 unique dental providers, an increase of 109 (2.01%) dental providers from the prior quarter at 5,434. MCNA reported 4,904 unique dental providers, an increase of 62 (1.28%) dental providers from the prior quarter at 4,842.

B. GEOACCESS

This subsection includes quarterly geo-access information based on self-reported geo-mapping data provided by MCOs in accordance with STCs 40(a). The HHSC Center for Analytics and Decision Support (CADS) unit has provided geo-mapping for previous 1115 waiver quarterly reports and is currently working towards collecting and submitting geo-mapping that coincides with Texas Government Code, Section 533.0061. Moving forward, travel time and distance geo access data will be presented with respect to metro, micro, and rural county provisions of dental, PCP, specialist, and behavioral health access for participants per quarter. HHSC will roll out data per quarter as the new system designed to provide this county level geo access data is developed and validated.

Attachments E1 and E2 list the counties subsumed under the categories of Metro, Micro, and Rural county distinctions. Counties for the dental providers are listed in Attachment E1 and counties where PCPs are housed are listed in Attachment E2. Travel time standard compliance for PCPs and dentists per county are listed in the G Attachments while distance standards are listed in the H Attachments. In addition to the HHSC CADS data, MCO self-reported pharmacy geo access standard compliance information can be found in Attachment J. The requirements for provider types vary by program and population as described below.

- All STAR, STAR Kids and STAR+PLUS members: PCPs, cardiovascular disease specialist, general surgeon, obstetrician/gynecologist for female members, ophthalmologist, orthopedist, psychiatrist, outpatient behavioral health services, acute care hospitals and pharmacy;
- Children in STAR, STAR Kids, and STAR+PLUS: otolaryngologist (ENT);
- Adults in STAR+PLUS: urologist;
- Dental members: main dentists, pediatric dentist, endodontist, oral surgeons, orthodontist; periodontist and prosthodontist.

For all STAR, STAR Kids, and STAR+PLUS SDAs, the following benchmarks will be applied for access to PCPs and dentists:

- 90% – two PCPs for children and adults; and
- 90% – access to at least one of all other provider types for adults and children.
- 10 miles - Distance standard for participant access to PCPs in metro area services
- 20 miles - Distance standard for participant access to PCPs in micro area services
- 30 miles - Distance standard for participant access to PCPs in rural area services
- 15 minutes - Travel time standard for participant access to PCPs in metro area services
- 30 minutes - Travel time standard for participant access to PCPs in micro area services
- 40 minutes - Travel time standard for participant access to PCPs in rural area services

If the MCO does not meet the geomapping mileage standards, it may submit a time-limited special exception request. The request must include supporting detail explaining why the exception should be granted. HHSC staff review the exception request and supporting detail. HHSC staff may consider additional factors such as known marketplace issues. HHSC may grant an exception for the quarter in which the exception was submitted and up to three subsequent state fiscal quarters and plans will not be subject to remedy.

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

- 95% –main dentist in metro areas within 30 miles;
- 95% –main dentist in micro areas within 30 miles; and
- 95% –main dentist in rural areas within 75 miles.

1. PCP and Dental Network Adequacy - Travel Time

   Attachment G1-G3 contain data on PCP and dentist compliance with network adequacy travel time standards. Across all programs, the majority of MCOs and SDAs met and exceeded the 90% standard for the ability of adults residing in a metro county to access 2 PCPs within 15 minutes and the ability of adults in micro counties to access 2 PCPs in 30 minutes. There were less than 10 exceptions to this pattern that can be found across programs. Also, both dental programs exceeded the 90% standards for travel time for all three county types.

However, the rural county 40 minute travel time standard for adult access to 2 PCPs posed more of a challenge for each program. While most of the lower compliance scores were above 80%, in the STAR Program, El Paso first Premier Plan in El Paso was at 50% compliance and Molina Healthcare of Texas in Hidalgo was at 54% compliance. In the STAR+PLUS program, both MCOs in the El Paso SDA were between 60% and 70% compliance while Cigna Health Spring and Molina Healthcare in Hidalgo were at 49% and 57% compliance respectively. Most children have access to PCPs in Metro and Micro county areas but may have had more difficulty accessing PCPs in rural counties as compliance in rural areas ranged from 42% for STAR in Hidalgo at Molina to 100% compliance.

2. PCP and Dental Network Adequacy - Distance

Attachments H1-H3 contain data on PCP and dentist compliance with network adequacy distance standards. Both dental programs met the 95% standards for distance for all three county types. Across all programs, the majority of MCOs and SDAs met and exceeded the metro, micro, and rural county distance standards for children and adults PCP distance standards. For children, the two lowest scoring areas were both in the STAR program as Molina Healthcare of Texas failed to meet the micro standard in the Harris SDA and the rural standard in the Hidalgo SDA. For adults, scores well below the standard, at or under 70% were found in the STAR and STAR+PLUS programs for micro and rural areas. STAR Harris SDA at Molina Healthcare held the lowest score of 33% for adult micro county resident access to 2 PCPs. In the third quarter, Molina did not follow all the appropriate instructions for submitting the list of PCPs. The bulk of Molina's PCPs available under their STAR plan in Harris became difficult to trace in documentation. The provider access workgroup has been working with the MCOs to provide better reporting.

3. Pharmacy Geo-Access

Attachment J provides summaries of MCO self-reported geo-mapping data by plan and SDA for pharmacies. For all STAR, STAR Kids and STAR+PLUS SDAs, the following benchmarks applied:

- 75% – access to a network pharmacy in urban counties within 2 miles
- 55% – access to a network pharmacy in suburban counties within 5 miles
- 90% – access to network pharmacy in rural counties within 15 miles
- 90% – access to a 24-hour pharmacy in all counties within 75 miles

Certain areas continued to have deficiencies in meeting access standards in 2017 SFQ3. Most programs complied with the standard for urban county residents to be within 2 miles of a pharmacy in the STAR MRSA. There were only six exceptions to compliance. Fewer programs complied with the standard for members in suburban counties residing within 5 miles of one pharmacy in STAR+PLUS and non-MRSA STAR as there were several exceptions to compliance. It is important to note that 100% of members have access to mail order pharmacies; this serves as an important accessibility benefit for both members who require maintenance medications to manage chronic health conditions and for members who lack access to transportation.

In addition, according to the Pharmacy Benefits Managers (PBMs) for all MCOs, Medicaid members may access any network pharmacy enrolled with the Texas Medicaid Vendor Drug Program within or outside of the distance criteria.

C. OUT-OF-NETWORK UTILIZATION

As required by Texas law,[1] the State monitors health and dental plans' use of out-of-network (OON) facilities and providers.[2] In each SDA, OON utilization should not exceed the following thresholds:

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

1. SFQ3 2017

Attachment D details the OON utilization rates by program, MCO and SDA. The following plans listed below exceeded OON utilization standards in 2017 SFQ3. The State will continue to monitor these plans and will require corrective action or other remedies if appropriate. The following list does not include plans with initial low scores that were recalculated.

STAR

- Aetna: Bexar and Tarrant SDA
- Amerigroup: Dallas, Harris and MRSA Central SDAs
- Christus: Nueces SDA
- First Care: Lubbock and MRSA West SDAs
- Molina: Dallas and Jefferson SDAs
- Seton: Travis SDA
- Texas Children's: Harris SDA

STAR+PLUS

- Amerigroup: Harris SDA
- Molina: Dallas SDA

STAR Kids

- All STAR Kids MCOs failed to comply with the standard for at least one SDA.

Note: Continuity of care provisions continue to be in place for STAR Kids MCOs which allow members to continue seeing existing physicians and specialists, even if that provider is out-of-network, through April 2017. All ten STAR Kids MCOs extended this provision for 12 months from implementation. STAR Kids was implemented on November 1, 2016. Dental plans reported OON utilization well below

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

the 20% threshold at 0% for 2017 SFQ3. In the Dental Program, the 20% standard for "other services" applies to out-of-network dental services.

2. Special Exceptions for Out-of-Network Utilization Standards

Special Exception Requests (SERT) may be granted for MCOs that do not meet one or more of the Out-of-Network utilization standards. If an MCO does not meet one or more of the standards when submitting their quarterly deliverable(s), the MCO may submit a SERT. If approved, the MCO must submit the special calculation report within five business days of the SERT approval. The special calculation reports should exclude each provider(s) for which the SERT was approved.

IV. OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

This section addresses the quarterly requirements for STC 70 regarding outreach and other initiatives to ensure access to care. The Medicaid Managed Care Advisory Committee meeting update addresses STC 70. In previous reports, the Dental Stakeholder Updates addressed STC 41(c) which states that the state will continue to hold quarterly meetings with dental stakeholders, including dental care providers, as required under the *Frew* consent decree. However, the dental stakeholder meetings are no longer required under the *Frew v. Smith* lawsuit.

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 2017 D6Q3 Demonstration period (April-June 2017) MAXIMUS sent 274,452 enrollment mailings to potential STAR, STAR Kids, and STAR+PLUS clients, and 187,793 mailings to potential Dental Program clients. MAXIMUS field staff completed 28,550 home visit attempts for these programs and 160,490 phone call attempts. Additionally, MAXIMUS completed 6,438 field events, which included 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 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;
- The role of the primary care physician 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

HHSC attended the Texas Dental Association (TDA) meeting on May 5, 2017, which included stakeholders, DMOs and state staff. HHSC posted proposed changes to therapeutic dental services policy through the HHSC website, and reviewed and incorporated stakeholder feedback. HHSC also solicited feedback from stakeholders such as the TDA, Texas Academy of Pediatric Dentistry, and Texas Academy of General Dentistry on policy issues as needed.

C. MEDICAID MANAGED CARE ADVISORY COMMITTEE

The State Medicaid Managed Care Advisory Committee (SMMCAC) serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care.

A committee meeting was held on May 11, 2017. At the meeting, the Committee developed and adopted its strategic plan. The strategic plan will guide the Committee for the next two years. The next meeting was held on August 23, 2017, as the Committee meets quarterly. The outcome of the August 2017 meeting will be outlined in the 2017 SFQ4 report.

D. PUBLIC FORUM

In accordance with STC 14, Post Award Forum, HHSC afforded the public with an opportunity to provide comments on the progress of the Demonstration. The Medical Care Advisory Committee (MCAC) met on June 15, 2017. The date, time, and location of the MCAC were published on the HHSC website prior to the meeting.

During the June 15, 2017 MCAC meeting, Jamie Snyder, Associate Commissioner for Medicaid and Children's Health Insurance Program (CHIP) Services provided an overview of the outcomes of the 85th Regular Legislative Session, 2017. The legislative session, which ended on May 29, 2017, was followed by a 30-day special session which began on July 18, 2017. Stemming out of the regular legislative session, are a number of bills which HHSC tracked and which were ultimately approved by the legislature.

Additionally, Associate Commissioner Snyder provided an update on the 1115 waiver informing the MCAC that, in January 2017, HHSC submitted a letter to CMS requesting a 21-month extension beyond the 15-month extension which is due to expire at the end of 2017. HHSC is in ongoing discussions with federal partners regarding the extension and/or renewal of the waiver.

Members of the MCAC provided comments and questions related to specific bills from the legislative session. No members of the public provided comment regarding areas Associate Commissioner Snyder’s updates.

The next meeting was held on August 17, 2017. The outcome of the August 2017 meeting will be outlined in the 2017 SFQ4 report.

E. INDEPENDENT CONSUMER SUPPORTS SYSTEM PLAN

The structure and operation of the Independent Consumer Supports System (ICSS) aligns with the core elements provided in STC 21. The Texas ICSS consists of the HHSC Medicaid/CHIP Division, the Office of the Ombudsman, MAXIMUS and community support from the Aging and Disability Resource Centers (ADRCs). HHSC will provide relevant updates regarding ICSS in this section of the report each quarter.

1. Office of the Ombudsman

   Inadvertently, the updates reported for the Office of the Ombudsman in the 2017 Q2 was for 2017 Q3; therefore, we are reporting both 2017 Q2 and 2017 Q3 below.

   2017 Q2

   Compared to the first quarter of 2017, the Ombudsman Managed Care Assistance Team (OMCAT) averaged a call abandonment rate of 17% and a call volume increase of less than one percent, or 68 additional calls. The unit filled two vacant positions during the quarter which slowed down tenured staff while they trained new employees. Despite the November 1st roll out of the STAR Kids program, the unit did not experience any significant change in call volumes. The OMCAT unit continued to direct a managed care support network to better coordinate assistance provided to Medicaid managed care clients as mandated by state legislature. The network of entities includes the Ombudsman Office, the Long Term Care Ombudsman, the HHSC Medicaid / CHIP Division, Area Agencies on Aging, and Aging and Disability Resource Centers. The network facilitated two monthly meetings during the second quarter and will wait to hold its next meeting in April 2017 due to the Texas Legislative Session.

   2017 Q3

   Compared to the second quarter of 2017, the OMCAT abandoned 68% fewer calls averaging a call abandonment rate of six percent as compared to 17% in the previous quarter. The decrease in calls abandoned is due to a call volume decrease of 10%, or 994 fewer calls, and the unit being fully staffed. The office received an increase in complaints related to Superior STAR+PLUS in the Dallas service area. The complaints were regarding access to Long Term Care services such as a decrease in or not being able to access home health provider services, problems accessing home modifications and the plan not showing accurate waiver information in their system. The OMCAT unit continued to direct a managed care support network to better coordinate assistance provided to Medicaid managed care clients as mandated by state legislature. The network of entities includes the Ombudsman Office, the Long Term Care Ombudsman, the HHSC Medicaid / CHIP Division, Area Agencies on Aging, and Aging and Disability Resource Centers and now meets quarterly. The network facilitated a meeting during the third quarter and met again on June 22, 2017 for the fourth quarter.

2. Aging and Disability Resource Center (ADRC)

Local-level ADRC staff continue to participate in training activities about available resources and referral protocols. Training this quarter included the Medicare Improvements for Patients and Providers Act (MIPPA) Benefits Counseling Training and Conference in May, as well as sessions on how ADRCs can collaborate with their community partners to enhance services to veterans and their families. ADRCs also received training on the Disparate Impact Liability under the Federal Housing Authority, Tax Credit Developer Applications on the Texas Department of Housing and Community Affairs (TDHCA) website, and procedures for completing required Historically Underutilized Business (HUB) documents. The following are the dates and training topics:

- April 17: Texas Health and Human Services – Serving Texas' Veteran Population
- April 17: Texas Veteran's Commission – Overview of Programs & Services
- April 17: Samaritan Center – Hope for Heroes Program
- April 17: Southeast/Deep East Texas ADRC – Outreaching the Veteran Community
- April 26: Person-and-Family-Centered Best Practices in No Wrong Door Systems
- May 9-11: MIPPA and Benefits Counseling Training and Conference
- May 11: Older Adults - Aging Awareness & Sensitivity Training for I&R
- May 18: Mental Health in Focus
- May 23: Completing HUB Subcontracting Plans and Progress Assessment Reports
- May 31: Disparate Impact Liability under the Federal Housing Authority
- May 31: Tax Credit Developer Applications on the Texas Department of Housing and Community Affairs website
- June 21: National Aging and Disability Transportation Center Transportation Information and Referral
- June 27: Completing the Internal Control Structure Questionnaire
- June 27: VA Medical Foster Home Program: A Home Based Alternative to Nursing Home Care
- June 29: Responding to Elder Abuse: Resources for Information and Referral Programs

On April 17, 2017, the ADRC Advisory Committee convened and committee members received training on the types of services available to veterans and their families, as well as strategies for outreaching this population. The committee members also received an update from the Person-Centered Assistance subcommittee.

F. HHSC MANAGED CARE INITIATIVES

Senate Bill 760

HHSC has implemented several managed care program changes to meet requirements of Senate Bill 760, 84th Texas Legislature, Regular Session, 2015 and the CMS managed care final rule. These changes include:

- Revised time and distance standards for specific provider types based on geographic designations;
- New requirements for provider directories, including more frequent updates for both online and hard copy directories;
- MCO appointment assistance for members; and
- MCO requirements for expedited provider credentialing.

HHSC has also revised and initiated a pilot of its new network access reporting and analysis process. The pilot, which began Quarter 3 of state fiscal year 2017, included collection and analysis of time and distance data for primary care physicians and main dentists. HHSC intends to conduct a full baseline report for travel time every three years, and a full baseline report for distance analysis every year. The first report, including both travel time and distance analysis will include data from Quarter 4, Fiscal Year 2017 and will be sent to the MCOs by October 31, 2017. HHSC is currently working with stakeholders to establish and implement processes for quarterly monitoring of MCO compliance with the revised standards.

HHSC is also continuing to work with stakeholders to develop revised network access standards for community-based long-term services and supports. These changes are expected to go into effect by September 2018 in compliance with state and federal regulations.

Mental Health Parity Regulations

The March 30, 2016 final rule applied Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicaid Managed Care and Children's Health Insurance Programs. The rule requires equal treatment of behavioral health conditions (mental health and substance use disorders) and physical health conditions, which prevents managed care organizations (MCOs) from imposing less favorable benefit limitations to behavioral health conditions compared to medical/surgical conditions. State Medicaid agencies are required to demonstrate compliance with MHPAEA by October 2, 2017. CMS recently granted an extension to allow Texas to be in compliance by December 2017.

The Health and Human Services (HHS) parity workgroup is comprised of internal stakeholders including Medicaid and CHIP policy and program staff, and staff across the agency with expertise in mental health and substance use disorders, medical policy, data analytics, managed care, and pharmacy benefits. Texas, as one of ten states selected to participate in the Substance Abuse and Mental Health Services Administration (SAMHSA) Parity Academy, has been working with the State's assigned technical assistant and participating in various webinars and technical assistance calls. HHSC provided status updates to external stakeholders through advisory committees, such as the Behavioral Health Advisory Committee. HHSC met with its MCOs on several occasions to outline federal parity requirements and to discuss the non-quantitative treatment limitation (NQTL) review process. HHSC released NQTL tools to the MCOs to assess MCOs' use of processes, strategies, and evidentiary standards on the NQTLs of prior authorization, concurrent review, medical necessity criteria, and network participation to ensure parity. HHSC has been providing technical assistance to the MCOs on completing the tool and one-on-one feedback sessions as needed. HHSC received three of the NQTL responses back from all of the MCOs and is currently evaluating the responses. HHSC anticipates completing the NQTL analysis in mid-September.

Medicaid and CHIP Managed Care Regulations

HHSC continues to analyze, develop, and implement contractual and programmatic changes necessary to ensure compliance with the May 6, 2016, CMS Medicaid and CHIP managed care final rule. The changes will be made on an ongoing basis based on the rule effective dates. HHSC recently received an information bulletin from CMS indicating a possible delay in enforcement of managed care regulations effective in 2017. HHSC staff have worked closely with stakeholders, including MCOs, to identify any

provisions related to the final rule for which HHSC will request flexibility from CMS. HHSC has notified CMS of its plan to submit a letter requesting enforcement flexibility for certain provisions of the final rule, and anticipates the letter outlining this request will be finalized and submitted to CMS in September 2017.

V. 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 them as necessary. The types of adjustments include revisions for newborns, deaths, change of SDAs and the addition of Medicare eligibility or eligibility attributes.

The State continues to conduct the quarterly MCO encounter financial reconciliation process for 2017 SFQ3. 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.

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 70.

1. Managed Care Issues

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

VII. CONSUMER ISSUES

This section addresses quarterly reporting requirements in STCs 23, 40(a) and 70 regarding complaints and calls to HHSC Health Plan Management (HPM) staff and the Office of the Ombudsman's Medicaid Managed Care Helpline (MMCH), as well as complaints and appeals received by plans. This section 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 volume 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.

Attachments M1 through M4 detail the total calls received as well as performance standards for all MCOs and DMOs. Calls to the MCO member hotlines decreased by -1% in 2017 SFQ3. Call volume to the MCO provider hotlines decreased by -2.93% and calls to the behavioral health hotline increased by

5.89%. In the Dental Program, calls to the member hotlines increased by 2.59% and calls to the provider hotline increased by 4.8%.

The following table shows the number of hotline calls received per 1,000 members in the last four quarters. STAR Kids program enrollment numbers, such as the Children's Medical Center enrollments, are included in the counts for 2017 SFQ3 enrollments. The rate of member hotline calls received per 1,000 members decreased slightly from 2017 SFQ2 to Q3 across most plans. 2017 SFQ2 numbers have been updated. The 66% increase for Community Health Choice (CHC) may likely be due to STAR Kids ramping up. Trends will be noted once HHSC has compiled more data points for STAR Kids. For hotline calls, when standards are not met, HHSC staff members reach out to MCOs to inquire the reason for non-compliance and document appropriate remedies for all MCOs in the respective remedy logs.

Member Hotline Calls Received per 1,000 Members (2016 SFQ3 - 2017 SFQ3)

MCO	SF 16 Q4	SF 17 Q1	SF 17 Q2	SF 17 Q3	Percent Change from SF17 Q2 - SF17 Q3
Aetna*	520	523	183	180	-1.93%
Amerigroup*	254	240	293	277	-5.64%
BCBS*	242	318	178	186	4.59%
CHC*	176	176	536	891	66.08%
Children's Medical Center			741	1,047	41.25%
Christus*	572	721	513	491	-4.40%
Cigna-HealthSpring	710	569	308	308	0.14%
Community 1st*	234	291	246	240	-2.35%
Cook Children's*	211	222	72	77	7.06%
DentaQuest	87	72	142	139	-1.86%
Driscoll*	158	159	175	163	-6.86%
El Paso 1st*	164	152	127	112	-11.48%
FirstCare*	129	141	98	99	1.15%
MCNA	113	109	516	514	-0.29%
Molina*	885	933	238	237	-0.68%
Parkland*	247	246	151	154	2.08%
Scott & White	312	161	347	318	-8.47%
Sendero*	294	281	282	220	-22.15%
Seton*	505	402	225	231	2.65%
Superior*	252	257	126	125	-1.16%
Texas Children's*	137	133	323	326	0.92%
United*	804	700	234	235	0.38%
Statewide (excludes dental)	**282**	**275**	**234**	**235**	0.38%

*Enrollment and Hotline data includes CHIP program

The Majority of all MCOs and DMOs met the following hotline performance in 2017 SFQ2:

- 99% of all calls must be answered by the fourth ring;
- ≤ 1% busy signal rate for all calls (* for behavioral health no incoming calls receive a busy signal);

- 80% of all calls must be answered by a live person within 30 seconds (* N/A for provider hotlines);
- ≤ 7% call abandonment rate; and
- ≤ 2 minute average hold time.

MCO performance in meeting the standards listed above.

Member Hotline, Attachment M1 - Most MCOs met member hotline standards with the exceptions of BCBS, Christus, and First Care.

Behavior Health Hotline (BH), Attachment M2 - Most MCOs met behavior health hotline standards with the exceptions of Community First.

Provider Hotline, Attachment M3 - All providers met standards for SF 2017 Q3.

Behavioral Health Hotlines - At 98.57% compliance, Community First missed 100% standard for calls answered by the 4th ring by less than 1 percentage point.

Provider Hotlines - Provider hotline standards were met.

B. COMPLAINTS AND APPEALS RECEIVED BY PLANS

Attachment N shows the number of member complaints and appeals and provider complaints resolved by MCOs and DMOs. All Q2 numbers have been updated to reflect any late reporting by MCOs or data entry issues.

1. STAR, STAR+PLUS, AND STAR Kids

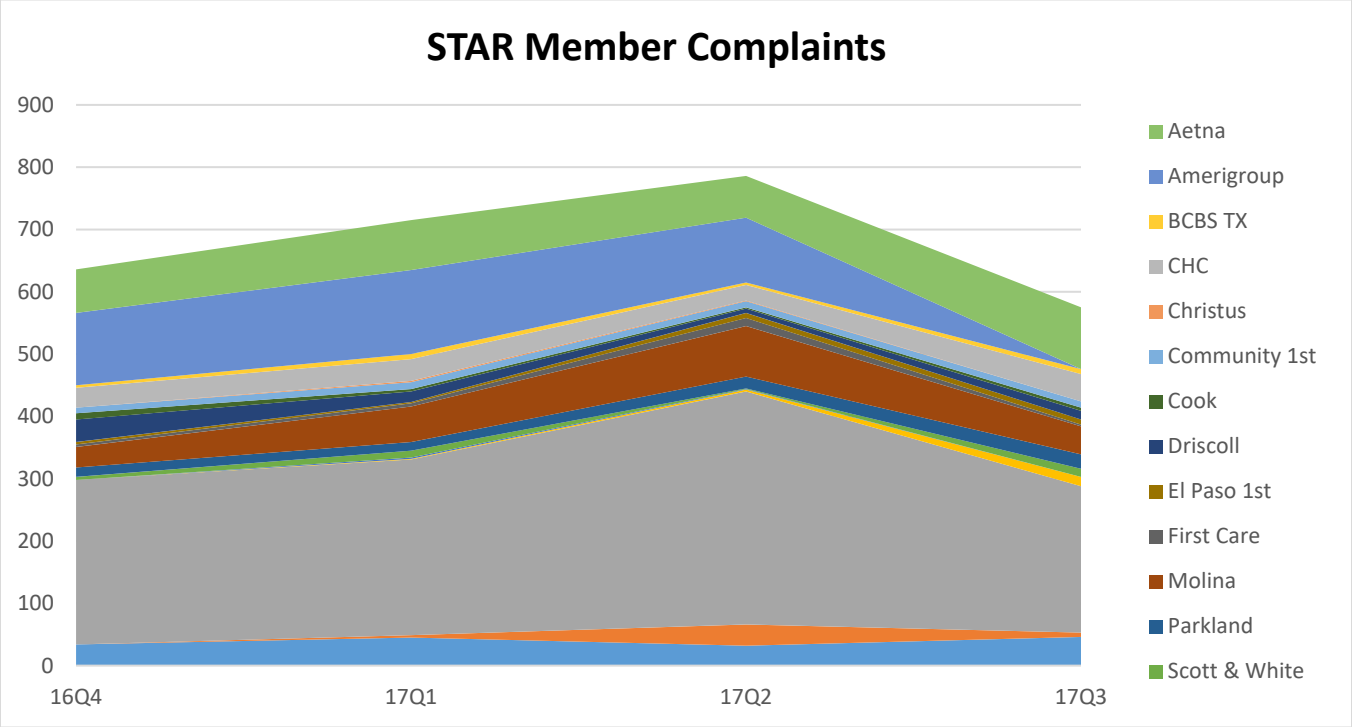
The total number of STAR complaints and appeals received by plans decreased by -39% from 2,581 in 2017 SFQ2 to 1,855 in 2017 SFQ3, as shown in the following figures below. STAR plans collectively reported 595 member complaints, 1008 member appeals and 216 provider complaints in 2017 SFQ3. The total number of STAR+PLUS complaints and appeals decreased from 4,505 in 2017 SFQ2 to 3,981 in 2017 SFQ3. STAR+PLUS plans reported 1,033 member complaints, 1,536 member appeals and 1,412 provider complaints in 2017 SFQ3.

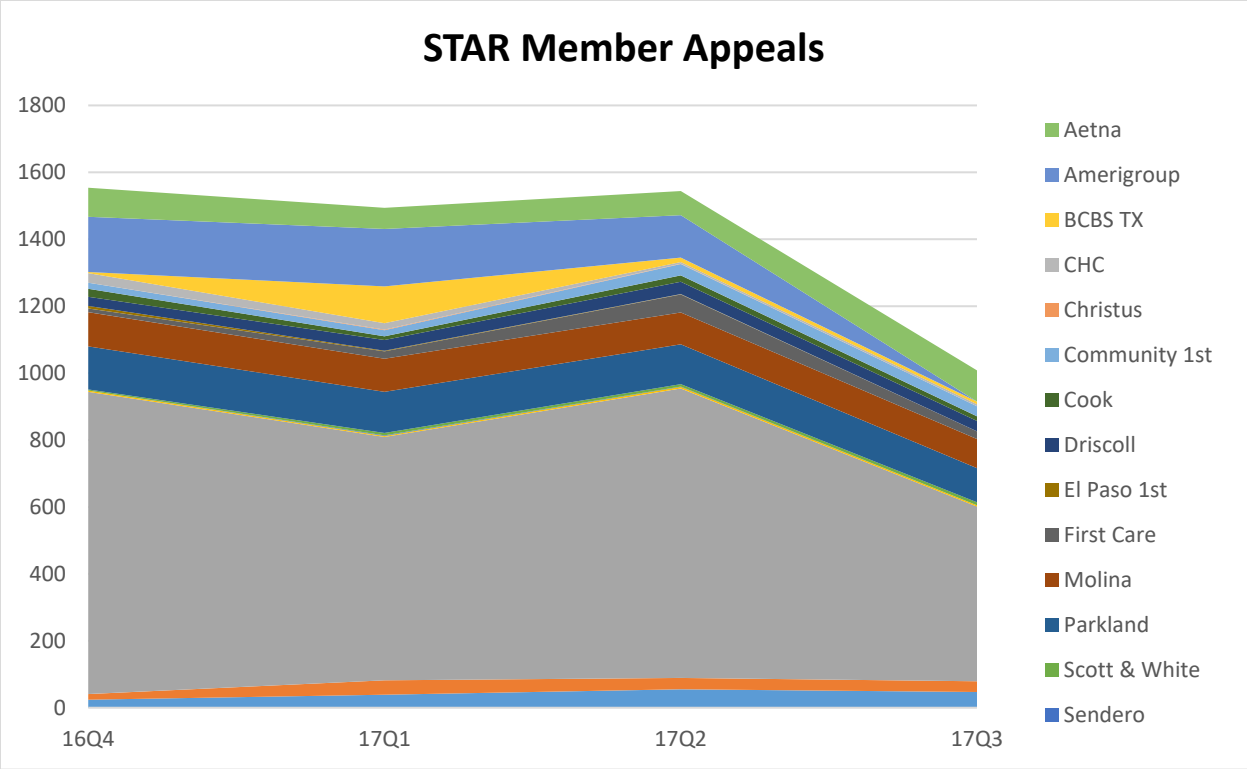
The total number of STAR Kids program complaints and appeals was 1,425, an increase of 36% from 605 in SFQ2 to 820 in SFQ3 as all three categories of appeals and complaints increased from the prior quarter. The STAR Kids member appeals category experienced the highest percentage change at 44% from 441 in SFQ2 to 637 in SFQ3. Provider complaints increased at 19% from 48 in SFQ2 to 57 in SFQ3 and member complaints increased at 9% from SFQ2 at 116 to SFQ3 at 126.

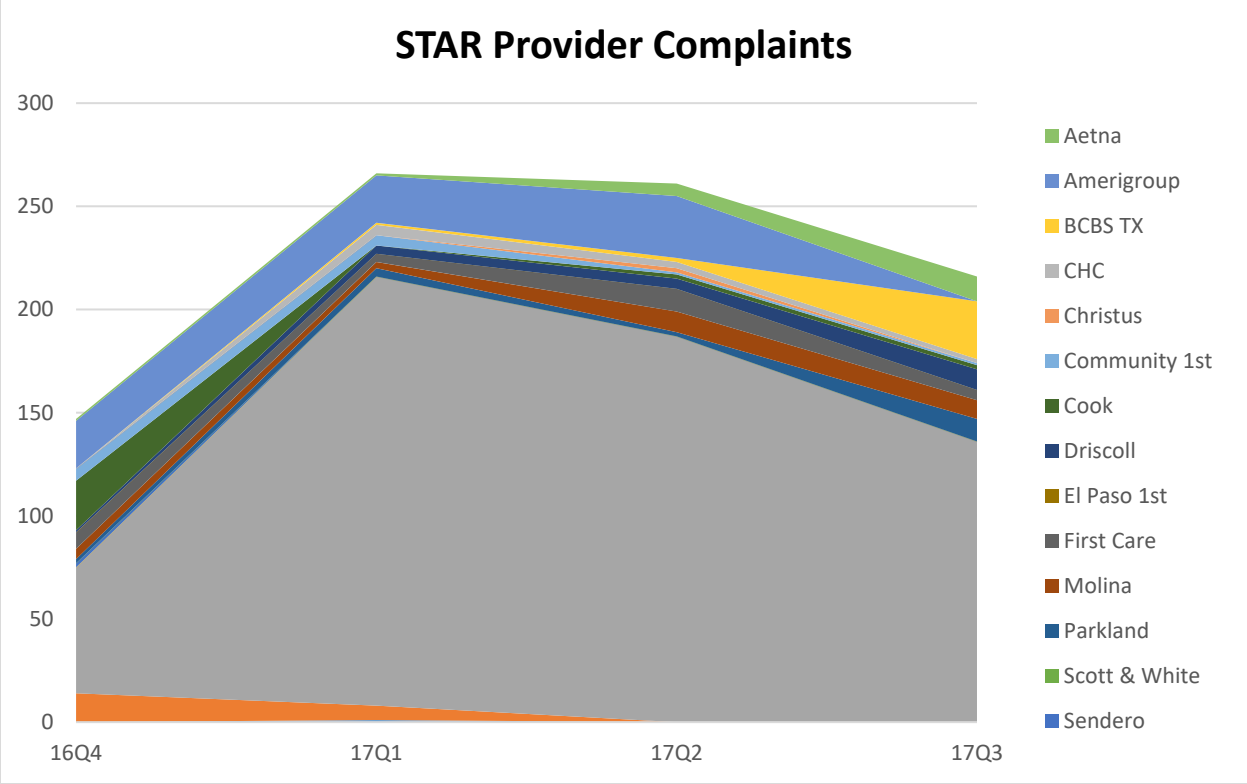
There were a few MCOs whose compliance numbers were well below the standard. In the STAR+PLUS program, Molina was at 66.67% compliance with the provider complaints standard in the Hidalgo SDA. Because the MCO did not meet standards for 30 day processing of provider complaints, HHSC has reached out to the MCO to resolve the issue. Also, BCBS Travis SDA obtained four scores well below average. In the STAR program, the MCO scored 20% compliance with the member appeal standard. HHSC is in contact with BCBS to resolve the issue.

The State's managed care contracts require plans to track and monitor the number of complaints and appeals resolved within 30-days of receipt and require the plans achieve 98% compliance with this benchmark in each SDA.

Complaints and Appeals Received by STAR MCOs (2016 SFQ3 – 2017 SFQ3)




STAR Member Appeals
1800
1600
1400
1200
1000
800
600
400
200
0
16Q4
17Q1
17Q2
17Q3
Aetna
Amerigroup
BCBS TX
CHC
Christus
Community 1st
Cook
Driscoll
El Paso 1st
First Care
Molina
Parkland
Scott & White
Sendero


STAR Provider Complaints
300
250
200
150
100
50
0
16Q4
17Q1
17Q2
17Q3
Aetna
Amerigroup
BCBS TX
CHC
Christus
Community 1st
Cook
Driscoll
El Paso 1st
First Care
Molina
Parkland
Scott & White
Sendero

STAR

Member Complaints

The majority of STAR MCOs achieved compliance with the timely resolution of member complaints. Scott and White at MRSA Central achieved 92.31% and is subject to liquidated damages.

Member Appeals

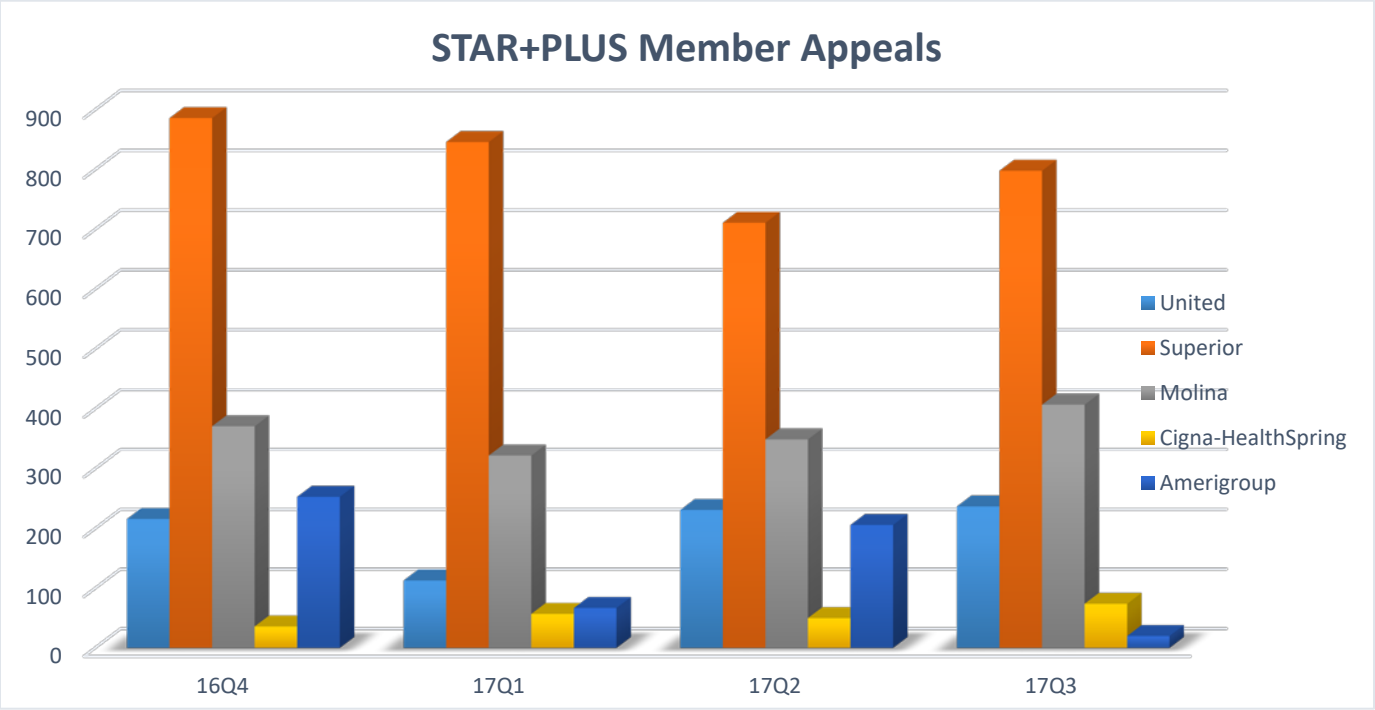
- Three MCOs did not meet the 30-day resolution standard for member appeals: BCBS, Cook, and Superior.
- For BCBS, HHSC has requested an explanation from the MCO and is awaiting response.
- Cook reported 14 member appeals for this reporting period. Twelve of these appeals were related to benefit denial and two appeals were related to pharmacy benefit denial, limitation/UR or management issue. Cook did not meet the 30-day resolution standard for member appeals. The Denials and Appeals Coordinator created a template for each appeal and tracking sheet to enter and record the upcoming due dates for each step in the appeal. Cook's Denials and Appeals Coordinator will then ensure that these due dates are entered into each individual case with reminders that will keep track of due dates and appear on the coordinator's daily worklist to ensure compliance with each step. This will help to ensure adherence to established timeframes.
- There were two noncompliance scores for Superior. In Hidalgo, the MCO was at 97.27%. To move Superior toward improved compliance, weekly report reminders and monitoring processes have been implemented to ensure outstanding and pending appeals are addressed timely. Additional staff have been trained as well to assist with increased appeal volume. In MRSA Central, the MCO was at 95%. Superior stated they identified reports that missed compliance standards for Member Appeals. Weekly report reminders and monitoring processes have been implemented to ensure outstanding and pending appeals are addressed timely. Additional staff have also been trained to assist with the increased volume of appeals received.

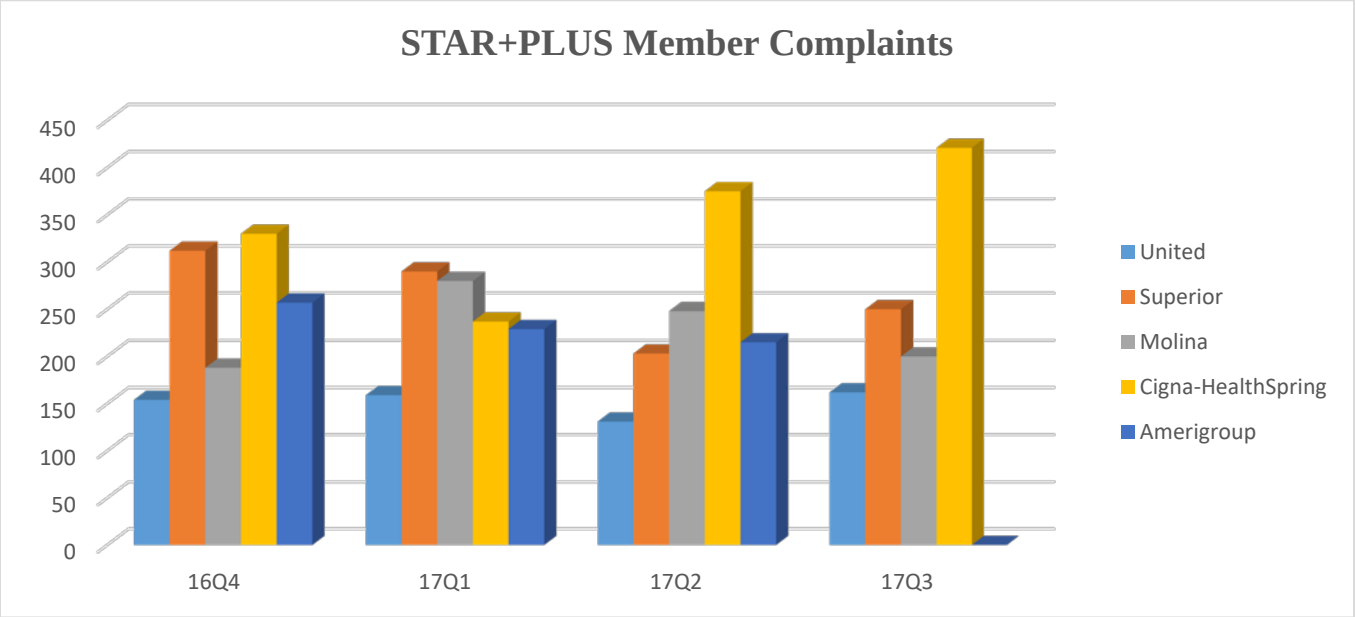
Provider Complaints

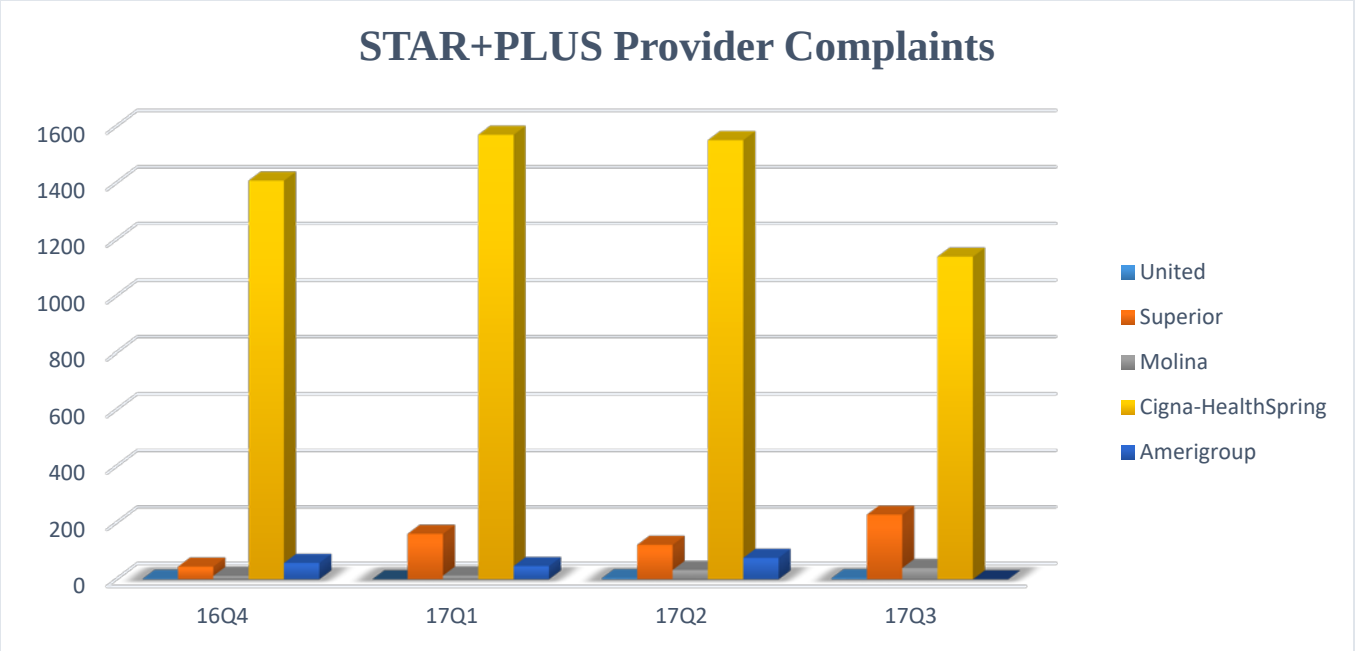
- Most STAR MCOs achieved compliance with provider complaints resolved 100% within 30 days with the exceptions of BCBS and Superior. HHSC has requested an explanation from BCBS. All three Superior MRSAs were just under compliance ranging from 90.32% to 95.45%. For MRSA West, Superior was at 95.45%. Superior stated, the contributing factors identified for complaints resolved outside of the standard turnaround time consist of untimely/infrequent follow-ups and an ineffective escalation process. Superior has updated and incorporated our escalation process to improve our process of conducting follow-ups with our internal partners in a timely manner and to help improve collaboration and coordination. This will also allow for the complaints to be addressed prior to exceeding 30 days.
- Regarding Superior MRSA Central and MRSA Northeast, provider complaints, the MCO informed HHSC that the contributing factors identified for complaints resolved outside of the standard turnaround time consist of untimely/infrequent follow-ups and an ineffective escalation process. Superior has updated and incorporated our escalation process to improve our process of conducting follow-ups with our internal partners in a timely manner and to help improve

collaboration and coordination. This will also allow for the complaints to be addressed prior to exceeding the 30 day expectation.

Complaints and Appeals Received by STAR+PLUS MCOs (2016 SFQ3 – 2017 SFQ3)







STAR+PLUS

Member Complaints

- STAR+PLUS MCOs achieved compliance with the timely resolution of member complaints.

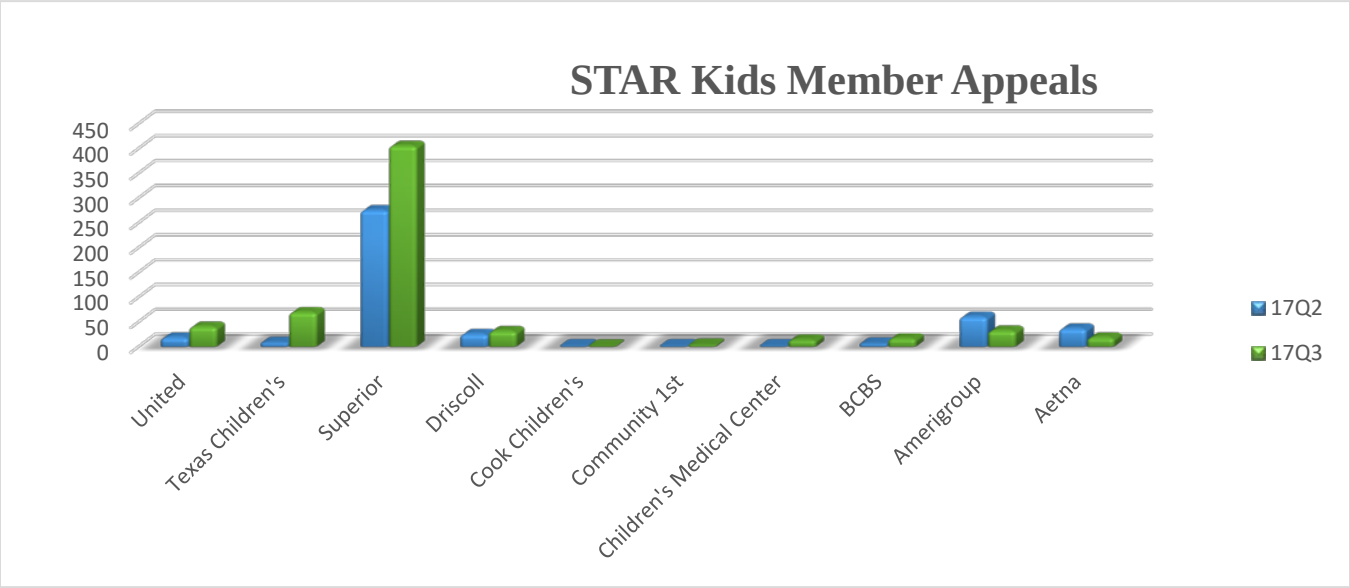
Member Appeals

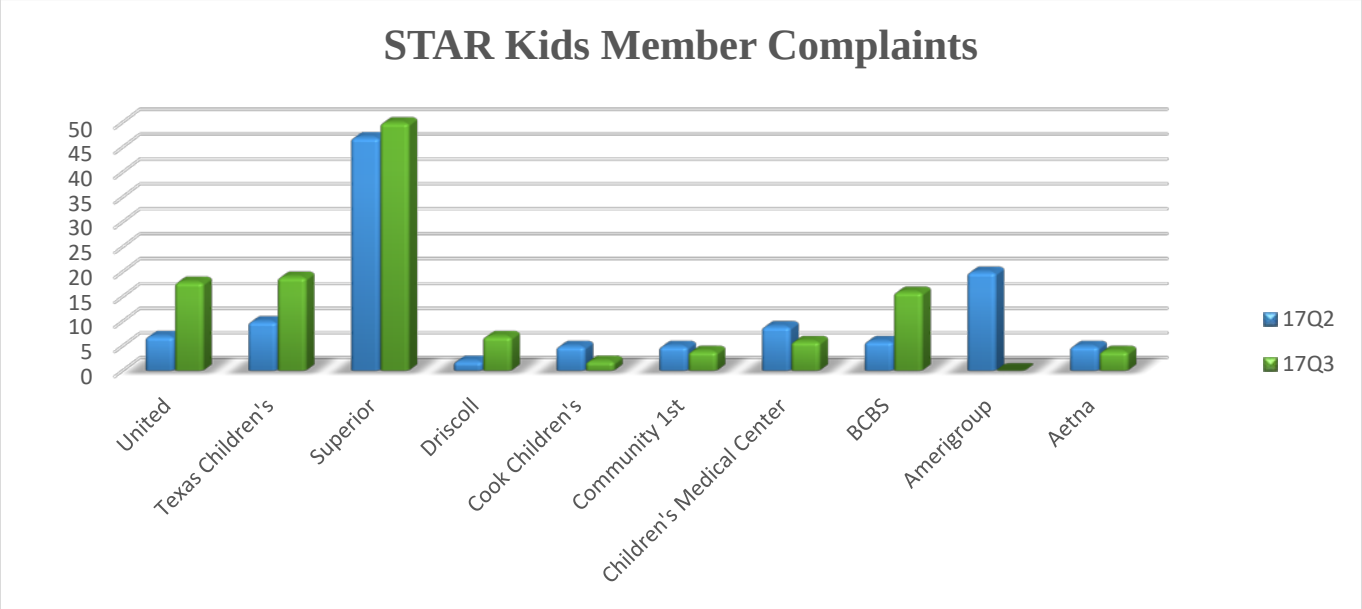
- Three of the five STAR+PLUS MCOs, Cigna-Health Spring, Molina and United, failed to reach compliance with complaint standards.
- Cigna-Health Spring Tarrant SDA MCO did not meet standards. Reasons for low compliance were assessed and as a remedial action, modifications have since been made to the pharmacy appeal process to increase oversight in order to prevent future requests from being completed after the allowed timeframe.
- United at MRSA Northeast SDA issues were corrected so that the MCO met all standards. The appeals over 30-days were 14-day extensions allowed by contract. Although the initial compliance number does not reflect standards met, the MCO met 100% of the 30-day and 14-day extension standards as clarified after the standard compliance deadline.

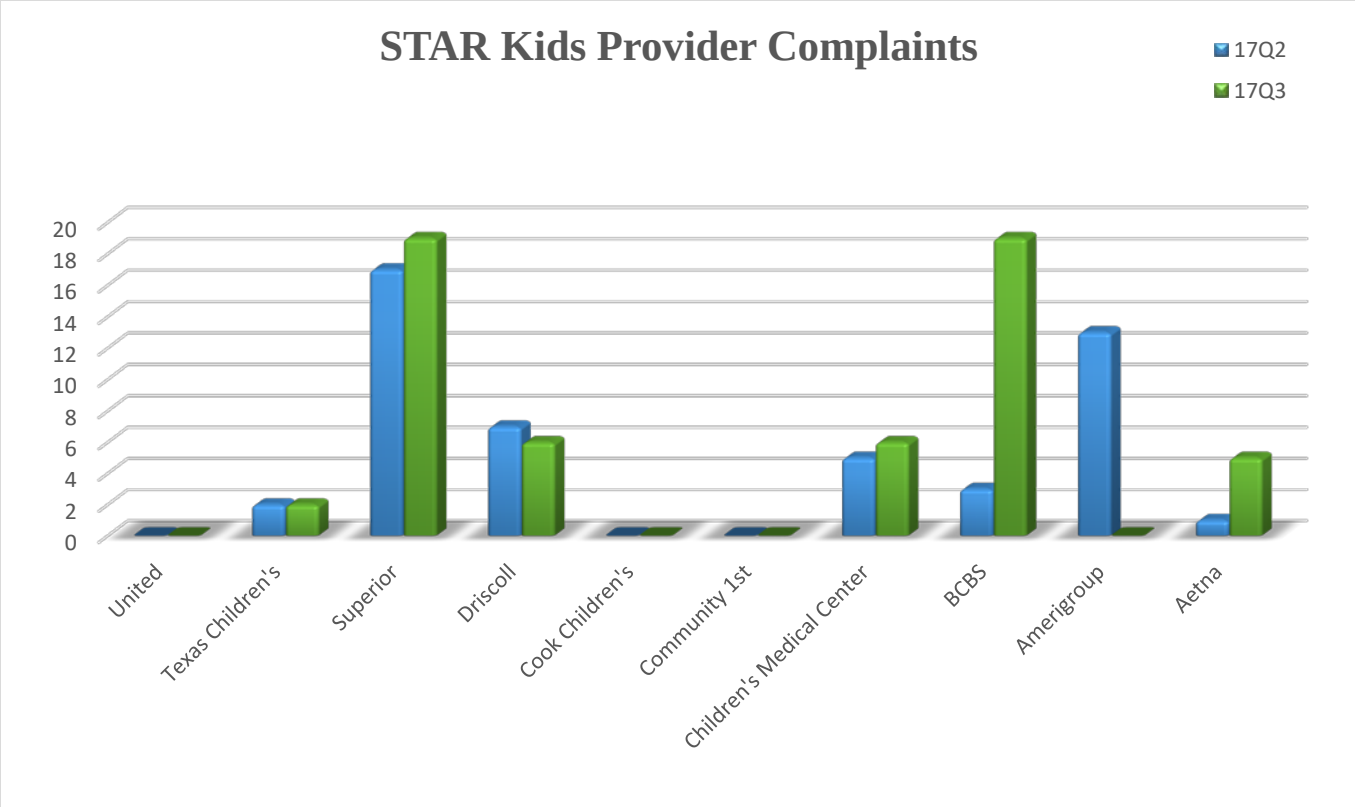
Provider Complaints

- Molina and Superior MCOs both failed to meet compliance standards for several SDAs. Molina provider complaints were a result of low volume and one claim not meeting standards. This is a first occurrence and is not expected to re-occur in Q4.

Complaints and Appeals Received by STAR Kids MCOs (2016 SFQ3 – 2017 SFQ2)







STAR Kids

Member Complaints

- STAR Kids programs were in compliance with standards for member complaint resolution.

Member Appeals

Aetna, BCBS, Superior, Texas Children's and United all fell short of compliance this quarter.

- For Aetna's 94.74% compliance, the 19 member appeals were reviewed and accounted for by HHSC staff. Sixteen were resolved, and three are pending.
- For the Travis SDA, BCBS reported only 66.67% compliance. HHSC is requesting an explanation from the MCO.
- Superior reviewed the 97.78% compliance score for the Travis SDA and identified reports that missed compliance standards for Member Appeals. Weekly report reminders and monitoring processes have been implemented to ensure outstanding and pending appeals are addressed timely. Additional staff have also been trained to assist with the increased volume of appeals received.
- The single complaint for United at Jefferson was upheld.
- Regarding the score of 96.43% for Texas Children's, the MCO stated there was one appeal request that was not routed correctly from a member service's work queue to the utilization management department's work queue. The appeal was processed upon discovery. However, it was past the 30 day timeframe. The routing within the system from member services to utilization management was also corrected upon discovery of the error.

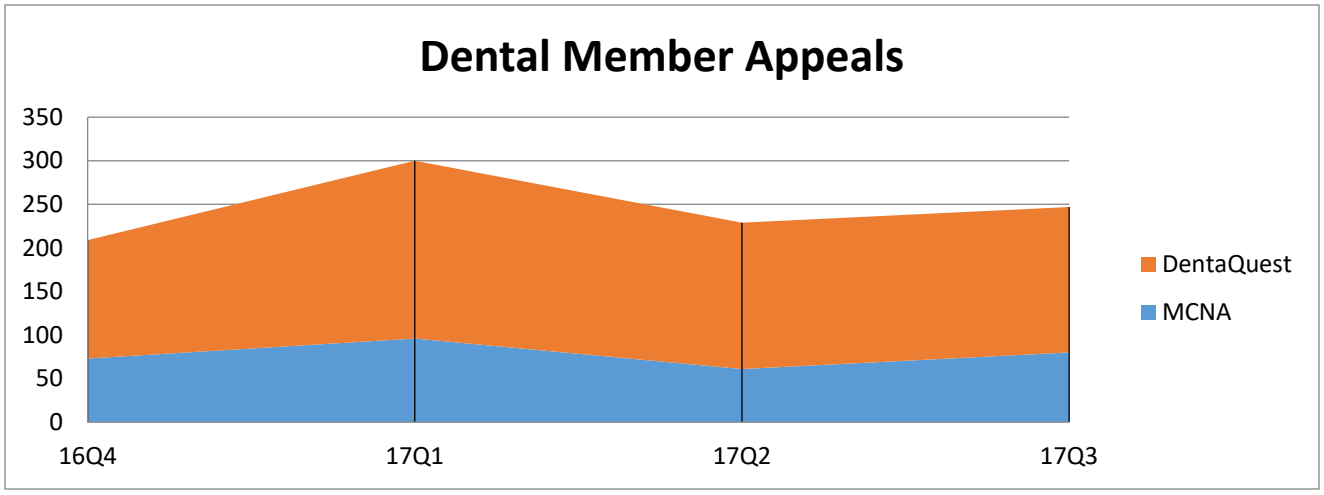
Provider Complaint

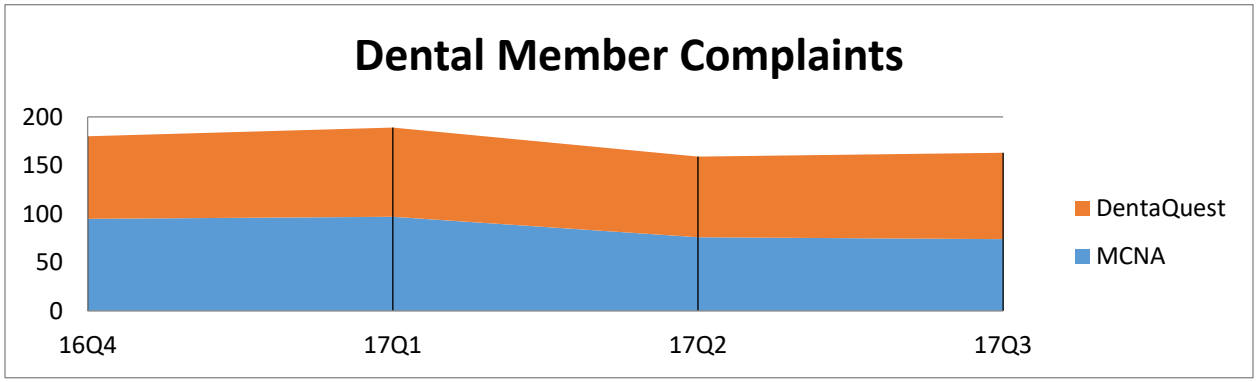
- BCBS Travis SDA was the only MCO that did not meet the compliance standard for provider complaints this quarter. HHSC is in contact with the MCO for an explanation.

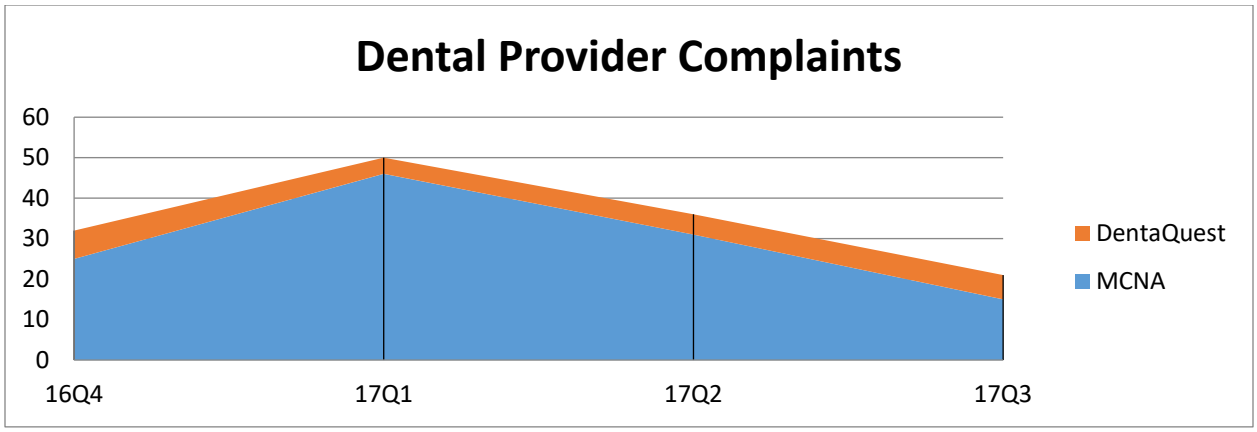
2. DENTAL PROGRAM

Between 2017 SFQ2 and 2017 SFQ3 dental member appeals increased by 7% from 229 in SFQ2 to 247 in SFQ3 while member complaints remained relatively stable at a slight increase of only 2.52% from 159 in SFQ2 to 163 in SFQ3. At -42%, complaints by providers significantly decreased from 36 in SFQ2 to 21 in SFQ3. MCNA and DentaQuest met all performance standards for the timely resolution of complaints and appeals in 2017 SFQ3.

Complaints and Appeals Received by DMOs (2016 SFQ3 – 2017 SFQ2)







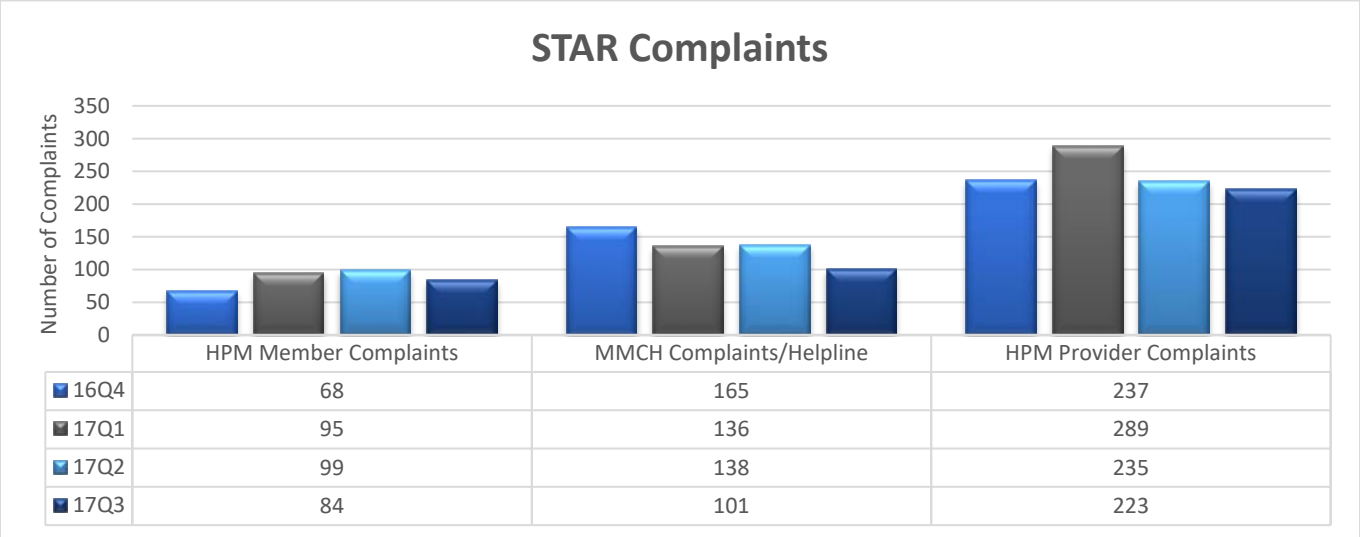
C. COMPLAINTS RECEIVED BY THE STATE

Attachment O includes information concerning Dental, STAR, STAR Kids and STAR+PLUS 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 member and provider complaints through the Office of the Ombudsman via the Medicaid Managed Care Helpline (MMCH). After investigating each complaint, staff determines whether or not it is substantiated. Substantiated complaints are those where there is a clear indication that agency policy was violated or agency expectations were not met (e.g., a member did not receive medically necessary benefits).

1. STAR

In the STAR program, the number of member complaints received by HPM decreased by -15% from (99 to 84) and the number of member complaints received by MMCH decreased by -27% (from 138 to 101) from 2017 SFQ2 to 2017 SFQ3. The most common member complaints received by HPM and MMCH were issues related to access to care and prescriptions. The number of provider complaints received by HPM decreased by -5% (from 235 to 223) in 2017 SFQ3. The most common type of provider complaint received by HPM was denial of claim.

Complaints to the State Regarding STAR (2016 SFQ3 - 2017 SFQ3)

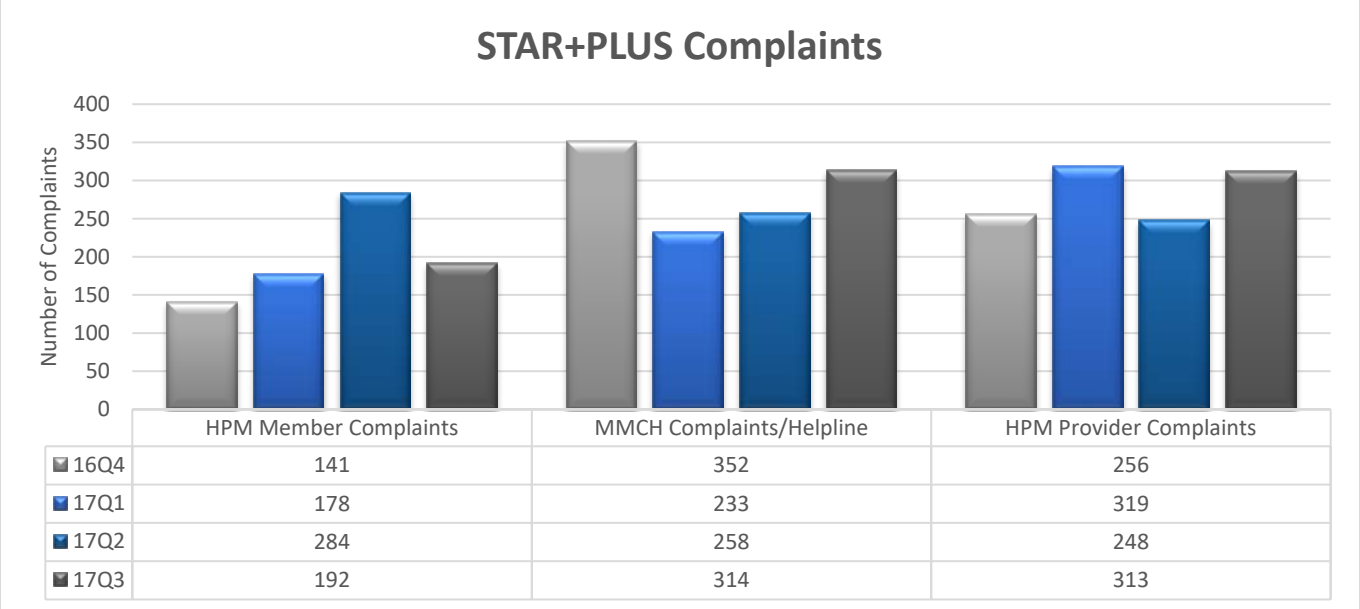


	HPM Member Complaints	MMCH Complaints/Helpline	HPM Provider Complaints
16Q4	68	165	237
17Q1	95	136	289
17Q2	99	138	235
17Q3	84	101	223

2. STAR+PLUS

Across the STAR+PLUS program, the number of member complaints received by MMCH increased by 21.71% (from 258 to 314) in 2017 SFQ2 to 2017 SFQ3. The member complaints received by HPM decreased by -48% (from 284 to 192) in 2017 SFQ2 to 2017 SFQ3. The most common issues among member complaints received by MMCH and HPM were related to access to care or to long term care, access to durable medical equipment, and benefits issues. The number of provider complaints increased by 26% (from 248 to 313) in 2017 SFQ2 to 2017 SFQ3. The most common issues among provider complaints was denial of claims.

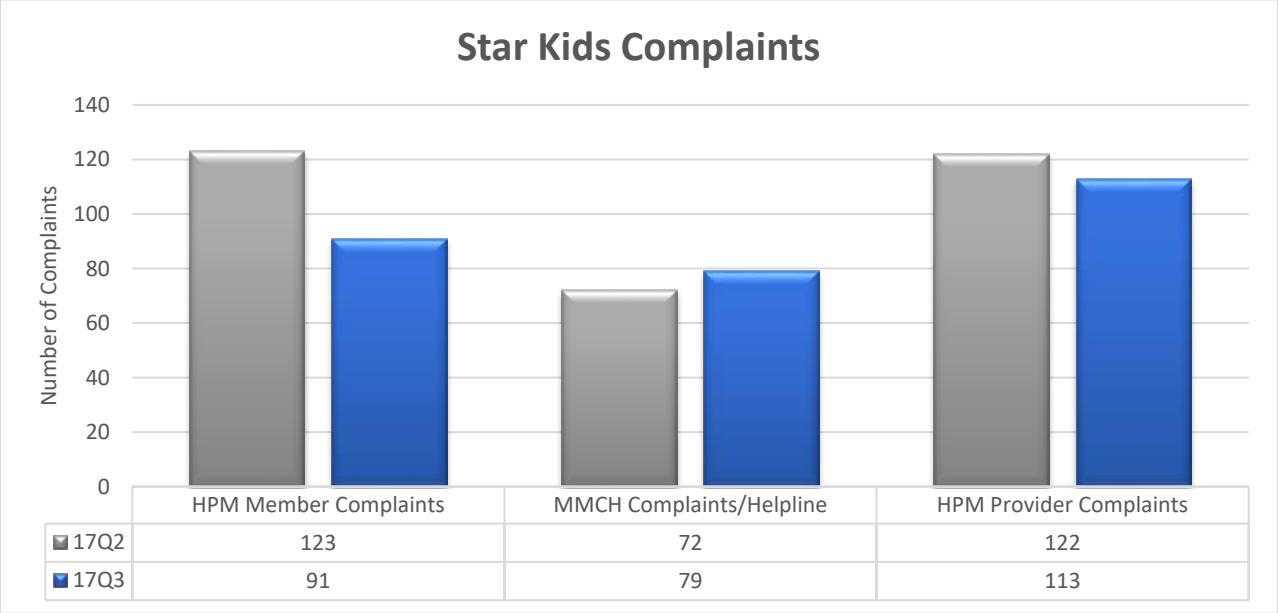
Complaints to the State Regarding STAR+PLUS (2016 SF32 - 2017 SFQ3)



	HPM Member Complaints	MMCH Complaints/Helpline	HPM Provider Complaints
16Q4	141	352	256
17Q1	178	233	319
17Q2	284	258	248
17Q3	192	314	313

3. STAR Kids

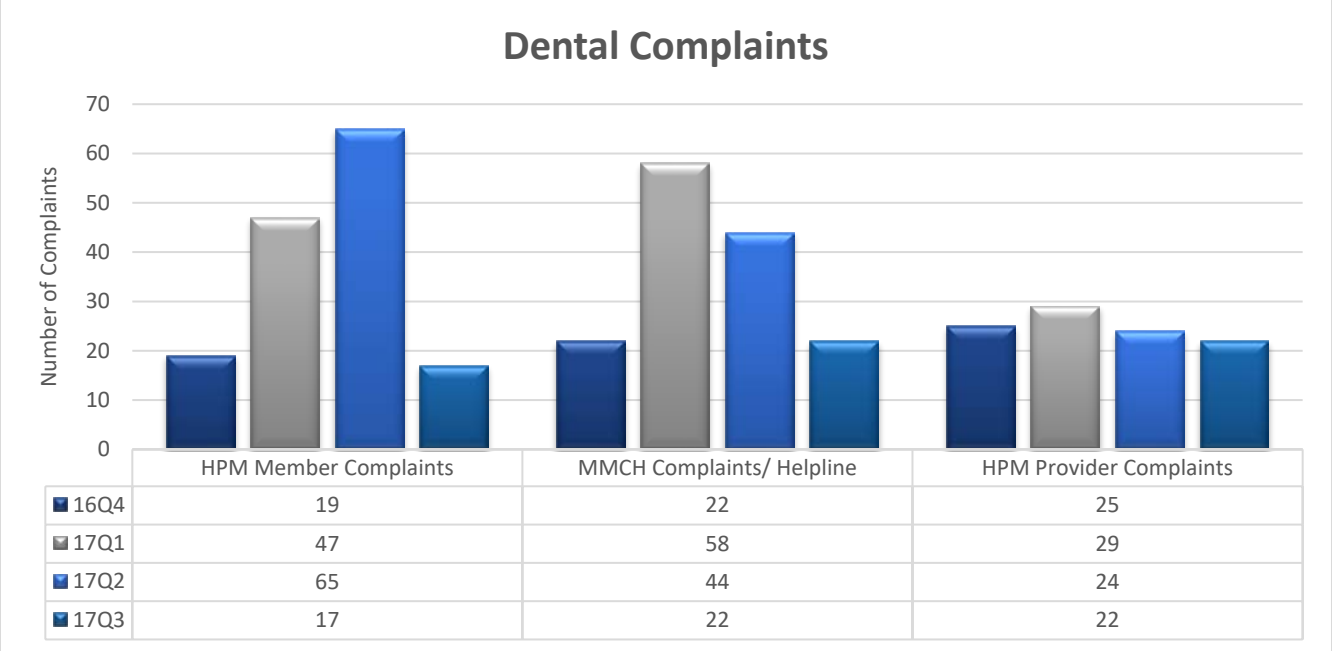
The STAR Kids Program experienced a reduction in HPM member complaints from 123 to 91 (-26%), an increase in MMCH complaints from 72 to 79 (9.72%), and a decrease (-7.38%) in HPM provider complaints, from 122 to 113. The most common HPM and MMHC complaints concerned access to care and access to long term services. The most common issue among provider complaints was denial of claims. As the program moves forward, more data will be available for comparison.



4. Dental Program

Across the Dental Program, complaints decreased significantly in two categories. The number of member complaints received by MMCH decreased by -50% from 44 in 2017 SFQ2 to 22 in 2017 SFQ3 and the number of HPM member complaints decreased by -74% from 65 to 17 from 2017 SFQ2 to 2017 SFQ3. Provider complaints decreased by -8% from 24 to 22 from 2017 SFQ2 to 2017 SFQ3. The most common member complaint for dental programming was incorrect enrollment information and the most common provider complaint was denial of claims.

Complaints to the State Regarding the Dental Program (2016 SFQ3 - 2017 SFQ2)



	HPM Member Complaints	MMCH Complaints/ Helpline	HPM Provider Complaints
16Q4	19	22	25
17Q1	47	58	29
17Q2	65	44	24
17Q3	17	22	22

VIII. QUALITY ASSURANCE/MONITORING ACTIVITY

This section covers quality assurance and monitoring activities that occurred in DY6Q3 SFQ3.

A. DY6Q3 QUARTER 3 UPDATE

Texas's external quality review organization (EQRO), the Institute for Child Health Policy at the University of Florida (ICHP), produced the preliminary calendar year 2016 quality of care reports which include health plan level results on Healthcare Effectiveness Data and Information Set (HEDIS) measures and Association for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDI) and Prevention Quality Indicators (PQI) measures. These results were shared with the health plans to identify any data issues before the final reports are run.

By the beginning of April, all MCOs and DMOs submitted their annual Quality Assessment and Performance Improvement (QAPI) program summary report. Each year, ICHP conducts a review of the QAPI program of participating health plans to assess elements reflecting the plan's ability to address regulations and assess the strength of the plans' Quality Improvement program.

In April, the MCOs and DMOs submitted their Administrative Interview (AI) evaluation tools for calendar year 2016. The AI evaluation tools are used to evaluate each plan participating in Medicaid Managed Care and CHIP on elements important to the provision of quality care and service to members, as well as compliance with state and federal regulations.

In May, the Executive Commissioner approved the redesigned medical pay-for-quality (P4Q) measures and methodology for calendar year 2018. HHSC's redesigned medical P4Q program creates financial incentives and disincentives for health plans based on their performance on a set of quality measures. Under P4Q, a percentage of the health plan's capitation is held at risk based on their performance on a number of key metrics. In June 2017, HHSC shared draft technical specifications with the MCOs and allowed comments to be submitted through the end of the month.

EQRO evaluations of revised 2017 Performance Improvement Project (PIP) plans were available to MCOs in April. The evaluations assessed whether or not recommendations from the original plan evaluations had been met. Two-year 2014 PIP final report evaluations were provided to MCOs in May. The 2018 Annual PIP Workshop was announced in early May and scheduled for July. The primary focus of the workshop is to discuss 2018 PIP topic selection, historical lessons learned and methodology for PIPs related to potentially preventable events. The Self-Directed Care PIP participants held meetings throughout the quarter to develop MOUs, operational protocol, reporting templates for non-traditional goods and services and decide on participant budgets. The project team includes HHSC, University of Texas@ Austin, Texas A&M Public Policy Research Institute, UT Heath San Antonio, STAR+PLUS MCOs, and the Stakeholder Advisory Group.

In June, the Executive Commissioner approved the redesigned dental P4Q program, and HHSC shared draft technical specifications for the program with the DMOs. The redesigned dental P4Q program incentivizes continued excellent performance by recouping from the dental plans capitation at risk if performance declines. HHSC accepted comments from the DMOs on the redesigned program and will share responses to comments next quarter.

Senate Bill 760, of the 84th Legislature, Regular Session, 2015, directed HHSC to establish and implement a process for direct monitoring of health plan provider network and providers in the network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. ICHP is conducting appointment availability studies for the purpose of monitoring appointment access and wait times. Obstetrics and gynecology--one of the four sub-studies for 2016--has been completed. Corrective action plan requests for managed care organizations that did not meet predefined thresholds for this study went out in Q2 SFY2017 Remedy Letters.

The National Core Indicators for Aging and Disabilities survey gauges the experiences of individuals who are aging, have physical disabilities, and receive long term services and supports in Texas. Designed by the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI), the survey focuses on individuals enrolled in STAR+PLUS, Older Americans Act (OAA) programs, and the Program of All-Inclusive Care for the Elderly (PACE). In June 2017, the 2015-2016 survey results were shared with MCOs. Texas will be repeating this survey for the 2017-2018 survey cycle.

ENCLOSURES/ATTACHMENTS

Find attachment descriptions listed below:

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

Attachment B – Enrollment Summary. The attachment includes annual and quarterly Dental, STAR, STAR KIDS, and STAR+PLUS enrollment summaries.

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

Attachment D – Out-of-Network Utilization. The attachment summarizes Dental, STAR, STAR Kids and STAR+PLUS out-of-network utilization.

Attachments E1-E3 – County Overviews for GeoMapping. Attachments E1 and E2 list the metro, micro and rural counties as reference for travel and distance standard geomapping data. Attachment E3 lists the PCP service delivery areas and their corresponding counties by county type.

Attachments G1-G3 –HHSC Travel Standards GeoMapping Summary. The attachments include the STAR, STAR Kids and STAR+PLUS plans' travel standards GeoMapping results organized by HHSC for PCPs and Dentist.

Attachments H1-H3 –HHSC Distance Standards GeoMapping Summary. The attachments include the STAR, STAR Kids and STAR+PLUS plans' travel standards GeoMapping results organized by HHSC for PCPs and Dentist.

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

Attachment L – Enrollment Broker Report. The attachment provides a summary of outreach and other initiatives to ensure access to care.

Attachments M1-M4 – Hotline Summaries. The attachments provide data regarding phone calls and performance standards of MCO and DMO Member and Provider Hotlines.

Attachments N – Complaints and Appeals to MCOs. The attachment includes Dental, STAR, STAR Kids and STAR+PLUS complaints and appeals received by plans.

Attachment O – Complaints to HHSC. The attachment includes information concerning Dental, STAR, STAR Kids and STAR+PLUS complaints received by the State.

STATE CONTACTS

Report developed and coordinated by:

Rachel Clarkson, MS, MA
Waiver Performance Management Specialist, Policy Development Support
Medicaid and CHIP Division
Office of Policy Development Support
4900 N Lamar, MC-H600
Austin, TX 79751
512-462-6232
Rachel.Clarkson@hhsc.state.tx.us

For questions regarding the waiver or this report, please contact:

Natoshia Petsch
Waiver Specialist, Policy Development Support
Texas Health and Human Service Commission
4900 N Lamar, MC-H600
Austin, TX 78751
(512) 487-3307
Fax (512) 487-3403
Natoshia.petsch@hhsc.state.tx.us

Kathi Montalbano
Manager, Policy Development Support
Texas Health and Human Service Commission
4900 N Lamar MC-H600
Austin, Texas 78751
(512) 730-7409
Fax (512) 487-3403
Kathi.montalbano@hhsc.state.tx.us

Date Submitted to CMS: October 13, 2017

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