Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2015 State Fiscal Quarter 2, December-February

Demonstration Year 4 Quarter 2, January – March

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I. INTRODUCTION

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

- Expand risk-based managed care statewide
- Support the development and maintenance of a coordinated care delivery system
- Improve outcomes while containing cost growth
- Protect and leverage financing to improve and prepare the healthcare infrastructure to serve a newly insured population
- 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 and STAR+PLUS programs, as well as Children's Medicaid Dental Services (Dental Program), which are found in the waiver's Special Terms and Conditions (STCs), items 20, 39(a), 40(b) and (c), 52, 65, and 67. 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; budget neutrality; member months; consumer issues; quality assurance and monitoring; the demonstration evaluation; and Regional Healthcare Partnerships (RHPs).

The State collects performance and other data from its managed care organizations (or "plans") on a State Fiscal Quarterly (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2015 SFQ2 (December-February) instead of Demonstration Year (DY) 4, Q2 ("2015 D2," covering January-March). Throughout the report, the State has identified whether the quarterly data relates to 2015 SFQ2 or 2015 D2.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2015 SFQ2, the State contracted with 18 STAR, 5 STAR+PLUS, and 2 Dental Program plans. Each MCO covers one or more of the 13 STAR service areas or 13 STAR+PLUS service areas, and each dental plan provides statewide services. Please refer to Attachment A for a list of the STAR, STAR+PLUS, and Dental plans by area.

B. MONITORING MCOS

The Health and Human Services Commission (HHSC) staff evaluates and routinely monitors managed care organization (MCO) performance reported by the MCOs or compiled by HHSC. If an MCO fails to meet a performance expectation, standard, schedule, or other contract requirement such as submission of deliverable timely or at the level of quality required, the managed care contracts give HHSC the authority to use a variety of remedies, including:

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

C. DEMONSTRATION FUNDING POOLS

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

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

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

II. ENROLLMENT AND BENEFITS INFORMATION

This section addresses STCs 39(a), 53, 65, and 67, including quarterly and biannual trends and issues related to STAR, STAR+PLUS, and Dental Program eligibility and enrollment; Medicaid eligibility changes; anticipated changes in populations and benefits; and disenrollment from managed care. Unless otherwise provided, quarterly managed care data covers the 2015 SFQ2 reporting period (December – February) instead of 2015 D2 (January – March). Similarly, biannual data covers the 2015 SFQ1-2 (September-February), instead of 2015 D1-D2 (October-March).

A. ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 67. Attachment B includes enrollment summaries for the three 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.

Overall, the enrollment in Texas Medicaid managed care programs, Dental, STAR and STAR+PLUS, decreased by 1.20 percent in 2015 SFQ2.

1. STAR

The number of members enrolled in STAR plans decreased by 1.49 percent from 2,910,410 in SFQ1 to 2,867,103 in SFQ2. Across the state, the largest increase in market share occurred within Blue Cross Blue Shield who experienced an increase in enrollment of 3.83 percent in SFQ2. Driscoll and Scott & White were the only other STAR MCOs to experience an increase in enrollment, but neither plan gained more than half a percent. All other MCOs experienced a decrease in enrollment by approximately a couple percentage points. By service delivery area (SDA), the enrollment decreased slightly in each SDA. El Paso SDA experienced the largest decrease in enrollment, still only 2.14 percent in SFQ2.

Market Share by STAR MCO (2014 SFQ3-2015 SFQ2)

STAR	2014 Q3	2014 Q4	2015 Q1	2015 Q2
Aetna	2.40%	2.47%	**2.53%**	**2.50%**
Amerigroup	19.84%	19.79%	**19.64%**	**19.63%**
BCBS	0.67%	0.73%	**0.78%**	**0.82%**
CHC	7.91%	7.88%	**8.00%**	**8.01%**
Christus	0.27%	0.25%	**0.25%**	**0.24%**
Community 1st	3.58%	3.65%	**3.76%**	**3.75%**
Cook Children's	3.20%	3.31%	**3.42%**	**3.41%**
Driscoll	4.22%	4.29%	**4.44%**	**4.52%**
El Paso 1st	2.15%	2.17%	**2.21%**	**2.22%**
FirstCare	3.42%	3.37%	**3.21%**	**3.19%**
Molina	3.73%	3.58%	**3.56%**	**3.53%**
Parkland	6.37%	6.33%	**6.40%**	**6.34%**
Scott & White	1.43%	1.49%	**1.38%**	**1.40%**
Sendero	0.38%	0.41%	**0.42%**	**0.42%**
Seton	0.49%	0.53%	**0.57%**	**0.58%**
Superior	25.25%	24.75%	**23.96%**	**23.96%**
Texas Children's	10.69%	11.01%	**11.44%**	**11.41%**
United	3.99%	3.99%	**4.05%**	**4.05%**

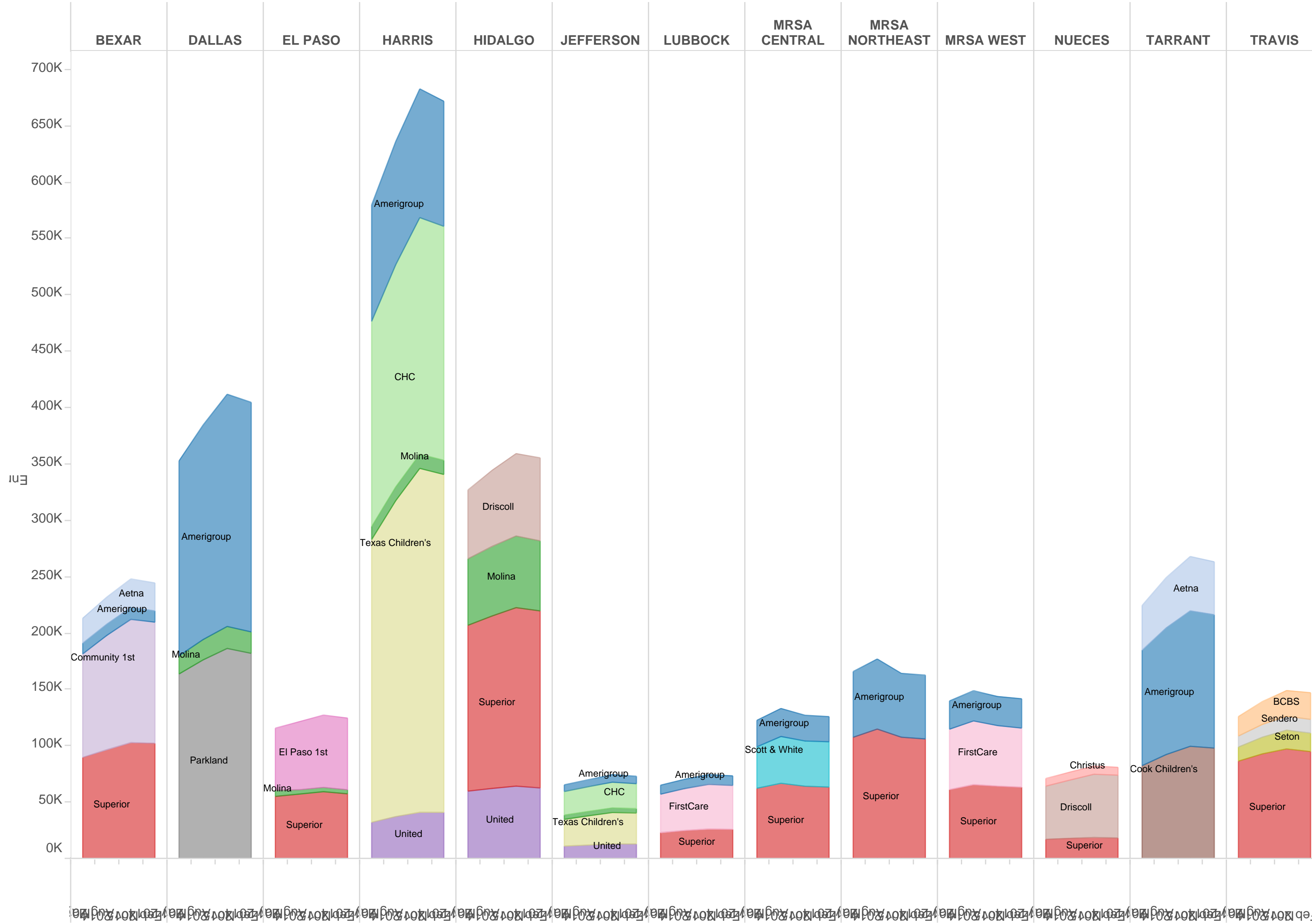
2. STAR+PLUS

The number of members enrolled in STAR+PLUS plans decreased by 0.2 percent from 518,152 in SFQ1 to 517,135 in SFQ2. Overall market share by MCO remained steady from the prior quarter, shown in the graph below.

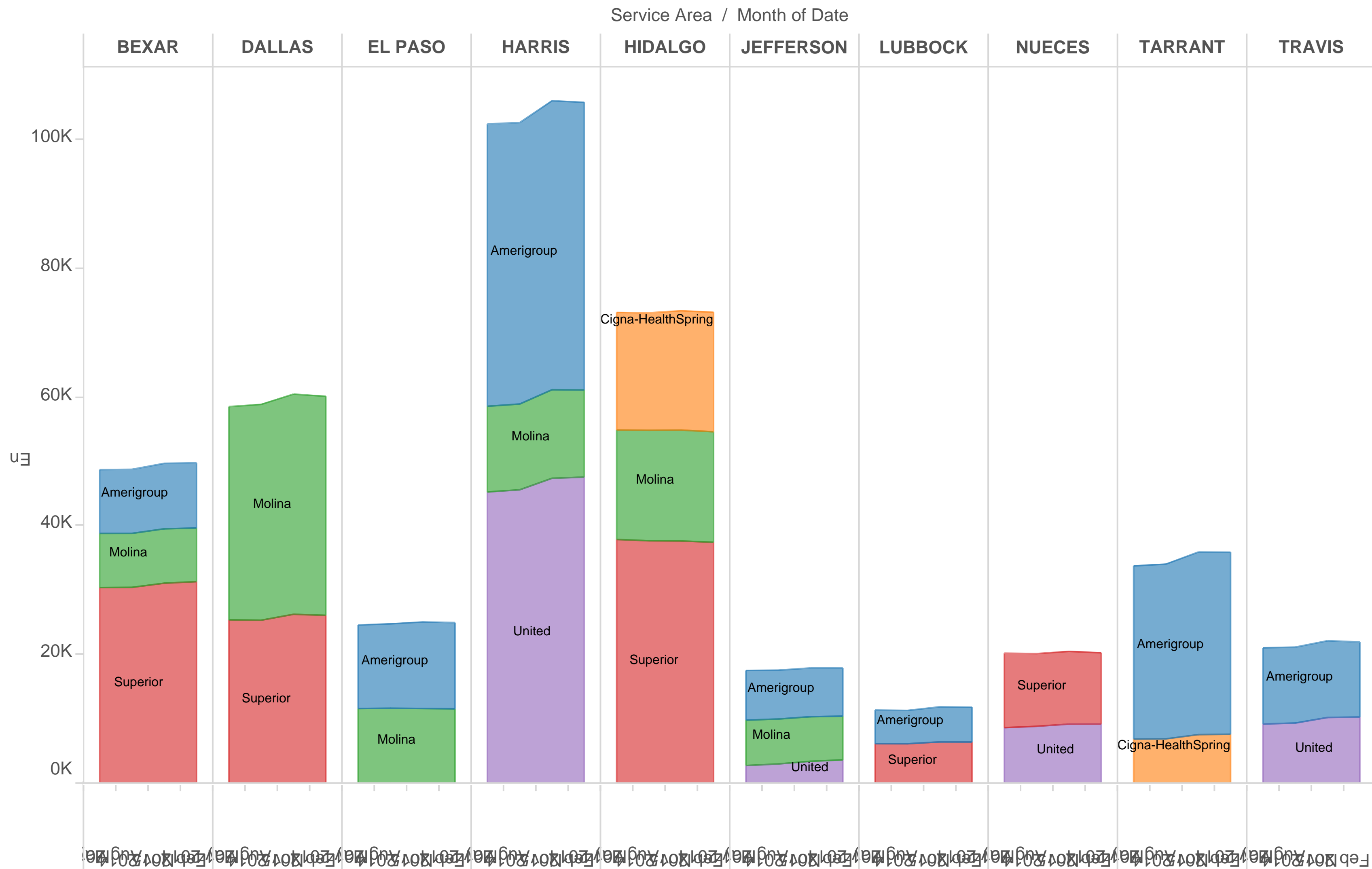
Market Share by STAR+PLUS MCO (2014 SFQ3-2015 SFQ2)

STAR+PLUS	2014 Q3	2014 Q4	2015 Q1	2015 Q2
Amerigroup	28.82%	28.77%	**26.59%**	**26.44%**
Cigna-HealthSpring	6.10%	6.09%	**8.89%**	**8.89%**
Molina	22.02%	22.09%	**17.79%**	**17.68%**
Superior	27.07%	26.87%	**27.49%**	**27.56%**
United	15.98%	16.17%	**19.25%**	**19.43%**

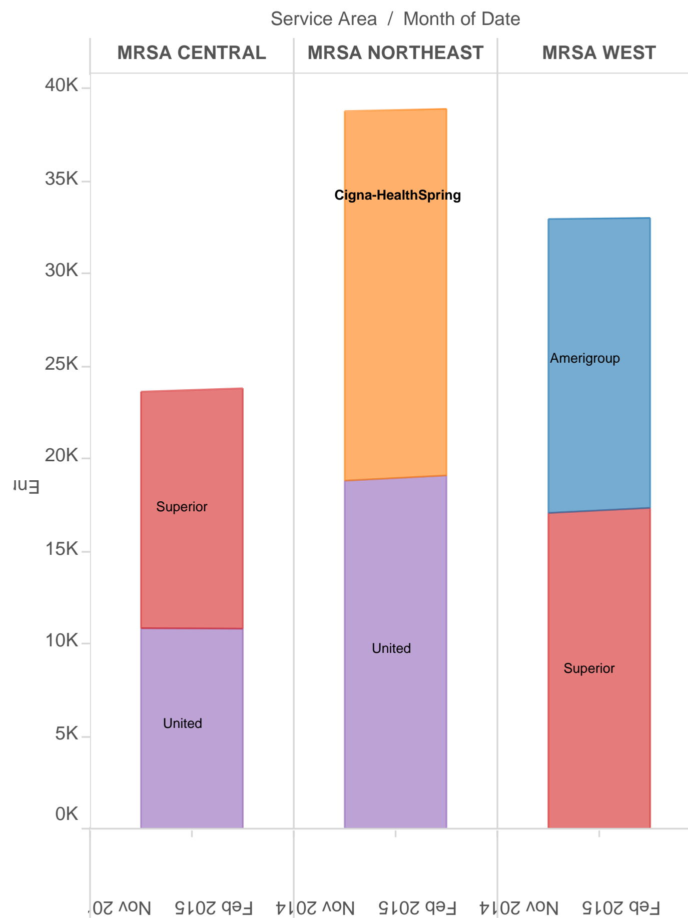
The two graphs on the following pages show enrollment by program, SDA, and MCO in the last four quarters.


STAR Program Enrollment by MCO and Service Area (2014 SFQ3-2015 SFQ2)
BEXAR
DALLAS
EL PASO
HARRIS
HIDALGO
JEFFERSON
LUBBOCK
MRSA CENTRAL
MRSA NORTHEAST
MRSA WEST
NUECES
TARRANT
TRAVIS
700K
650K
600K
550K
500K
450K
400K
350K
300K
250K
200K
150K
100K
50K
0K
Aetna
Amerigroup
Community 1st
Superior
Amerigroup
Molina
Parkland
El Paso 1st
Molina
Superior
Amerigroup
CHC
Molina
Texas Children's
United
Driscoll
Molina
Superior
United
Amerigroup
CHC
Texas Children's
United
Amerigroup
FirstCare
Superior
Amerigroup
Scott & White
Superior
Amerigroup
Superior
Amerigroup
FirstCare
Superior
Christus
Driscoll
Superior
Aetna
Amerigroup
Cook Children's
BCBS
Sendero
Seton
Superior

STAR+PLUS Non-MRSA Program Enrollment by MCO and Service Area (2014 SFQ3-2015 SFQ2)



STAR+PLUS MRSA Program Enrollment by MCO and Service Area (SFY2015 through Q2)



3. Dental Program

Total enrollment in the Dental Program decreased by 1.09 percent to 2,883,030 members in SFQ2. Market share in the Dental Program remained steady: DentaQuest has approximately 55 percent while MCNA has 45 percent.

B. ENROLLMENT COUNTS FOR THE QUARTER BY POPULATION

This subsection includes quarterly enrollment counts, as required by STC 67. 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 2014 DY3 Quarter 4. Enrollment counts are based on persons, and not member months.

Enrollment Counts (DY3 Q4, July-September 2014)

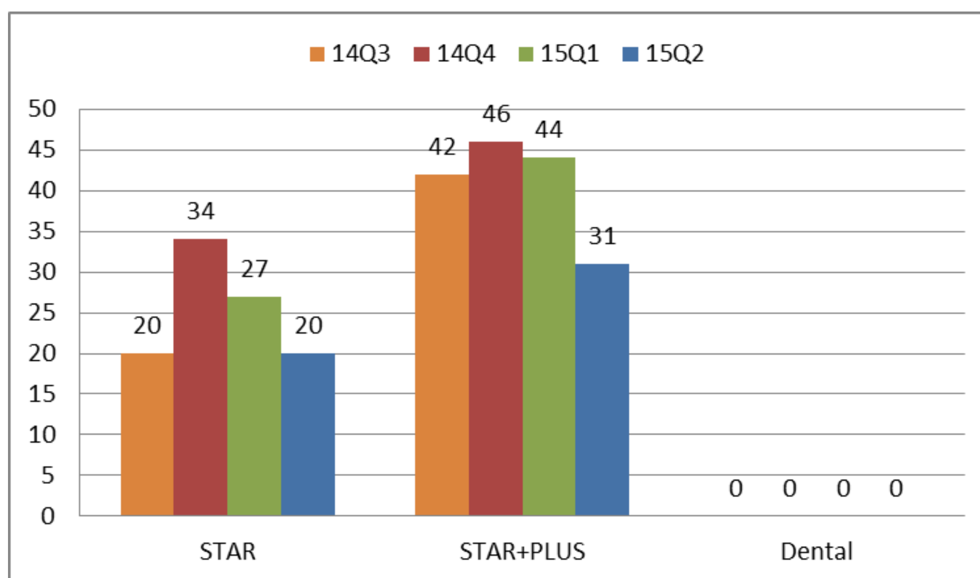
Demonstration Populations	Total Number
Adults	340,292
Children	2,765,350
Aged and Medicare Related (AMR)	382,883
Disabled	439,625

As a result of the carve-in of nursing facility services into managed care, approximately 47,000 individuals statewide transitioned from fee-for-service to STAR+PLUS. Approximately 50 percent of those transitioning to managed care selected to enroll with a particular MCO; the rest were auto-assigned by the state. This rate was consistent with the choice enrollment rates for recent expansions, such as members transitioning to STAR+PLUS in the MRSAs.

C. DISENROLLMENT

This subsection of the report addresses STC 39(b). In 2015 SFQ1 and SFQ2, the enrollment broker, MAXIMUS, reported 2,495 plan changes processed, an increase of approximately 30 percent. Regarding disenrollment requests from Medicaid managed care to the fee-for-service delivery model, the state received the following in SFQ1 and SFQ2: 47 disenrollment requests for STAR, 75 for STAR+PLUS, and none for the Dental Program. Members or their representatives initiated all disenrollment requests in SFQ1 and SFQ2. HHSC ensured that MCOs resolved member grievances related to their disenrollment requests, and because of these efforts no members were disenrolled from managed care in SFQ1 or SFQ2.

Managed Care Disenrollment Requests (SFY2014 Q3 to SFY2015 Q2)



D. ENROLLMENT OF MEMBERS WITH SPECIAL HEALTH CARE NEEDS

This subsection of the report addresses STC 39(b) regarding the enrollment into managed care for people with special healthcare needs. The state's Medicaid application asks potential enrollees to identify any family members that have special health care needs (MSHCN). MSHCN means a member including a child, or children with special health care needs (CSHCN) who (1) has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and (2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel. The state's enrollment broker conveys this and other information concerning potential members with special healthcare needs (MSHCN) to health and dental plans, who then verify whether the members meet the plans' assessment criteria for MSHCN. All STAR+PLUS members and Former Foster Care Children (FFCC) enrolled in STAR are deemed to be MSHCN.

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

HHSC has developed additional contract requirements related to MSHCN effective March 2015. The new language requires MCOs to include additional populations to the groups that must be identified as MSHCN including pregnant women identified as high risk and Early Childhood Intervention program participants. In addition, the new language defines contractual requirements regarding service management and developing appropriate service plans for MSHCN.

1. Reporting

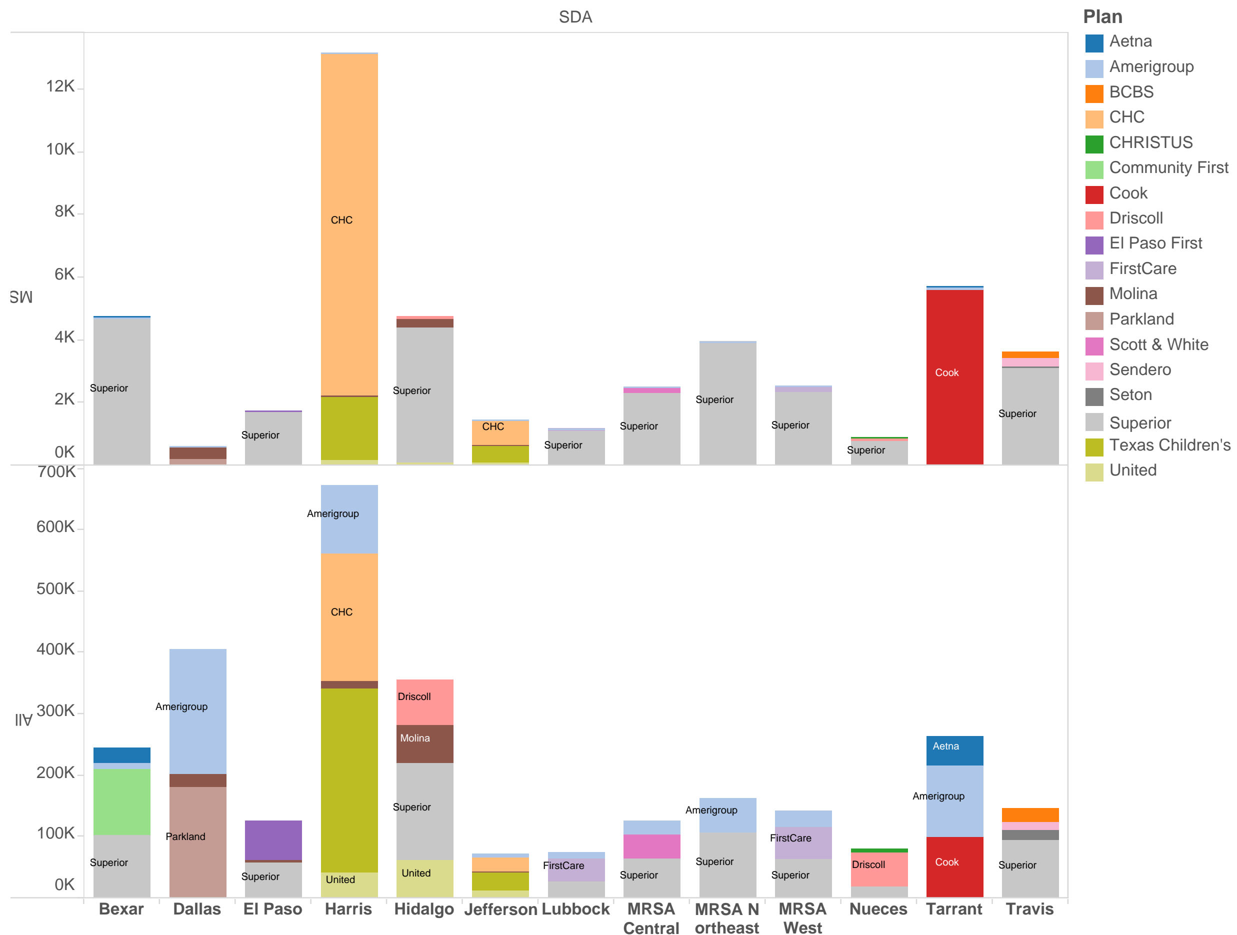
In the past, HHSC has provided the enrollment broker's MSHCN data in the annual reports. This data showed the number of self-identified MSHCN for the quarter, and did not reflect the total number of verified MSHCN. HHSC requested MCOs to submit the total number of MSHCN that they have verified. The data presented in Attachment Q of this report shows a snapshot of the total number of MSHCN for the month of February 2015. HHSC is developing a template for the MCOs to submit MSHCN data on a regular basis.

2. Analysis

All STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR+PLUS plans are required to provide service coordination to all members. In February 2015, there were a total of 46,790 children and adults that were identified as members with special health care needs in all STAR MCOs, which is less than two percent (1.63%) of all STAR members. See Attachment Q for detail by service area and MCO.

Half of all STAR members with special health care needs are concentrated in the Harris, Tarrant, and Hidalgo SDAs. Four STAR plans reported more than two percent of members were classified as MSHCN: Cook (5.72%), CHC (5.10%), Superior (3.51%), and Sendero (2.57%). The remaining plans reported less than one percent of MSHCN.

Total STAR Members Identified as MSHCN and Total STAR Enrollment by MCO and SDA (February 2015)



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

The number of MSHCN has increased over time for some plans that have changed identification processes. For example CHC, reported 322 in August 2014 and 11,717 in February 2015. CHC

attributes this increase to several factors: the inclusion of additional groups as MSHCN, increased efforts to reach members, and incorporating data analytics to identify members based on claims data. Superior is also using the enrollment broker data file to identify MSHCN resulting in higher numbers.

E. MEDICAID ELIGIBILITY CHANGES

No eligibility changes were made to the 1115 waiver populations in 2015.

F. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

Effective March 1, 2015, the STAR+PLUS MCOs became responsible for the delivery and payment of nursing facility services for STAR+PLUS members.

Also effective March 1, 2015, under the Dual Demonstration, HHSC began testing an innovative delivery model that combines health services for people with both Medicaid and Medicare coverage into one plan. The Texas plan involves a three-party agreement between a Medicare-Medicaid health plan, the state, and the federal Centers for Medicare and Medicaid Services (CMS), to provide individuals with the full array of Medicaid and Medicare services. The demonstration includes full-dual eligible adults (age 21 and above) who reside in a STAR+PLUS service area that currently receive their Medicaid benefits through the STAR+PLUS managed care program. The goal of the project is to better coordinate the care those individuals receive. The demonstration has been implemented for all dual-eligible members, except individuals in nursing facilities, in the following six counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant.

Beginning June 1, 2015, STAR+PLUS MCOs will be required to make Community First Choice (CFC) a benefit for certain individuals who meet an institutional level of care for a hospital, an intermediate care facility for individuals with intellectual disabilities or a related condition (ICF-IID), nursing facility or institution for mental disease (IMD) and upon assessment are determined to require attendant, habilitation, emergency response services (ERS) or support management.

HHSC anticipates the following caseload changes in managed care enrollment as shown in the chart below.

Medicaid Average Monthly Caseload Forecasts (FFY2014-FFY2017)

Current World	FY 2014	FY 2015	FY 2016	FY 2017
Total FFS	735,000	733,000	751,000	771,000
Total Managed Care	3,012,000	3,346,000	3,449,000	3,537,000
Total Medicaid	3,747,000	4,079,000	4,200,000	4,308,000
% Managed Care	*80%*	*82%*	*82%*	*82%*

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

DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly reporting requirements found in 39(a) and 67. Supporting data is located in Attachments C through K. HHSC routinely reviews various measures related to network adequacy, including those reported in the following section of this report: provider network counts, geoaccess, and out-of-network utilization. HHSC monitors these measures in combination with member complaints in order to assess the adequacy of MCO provider networks.

A. PROVIDER NETWORKS

This subsection includes quarterly healthcare and pharmacy provider counts for STAR and STAR+PLUS, and dental provider counts for the Dental Program. The provider network methodology is contained in Attachment C1, provider network counts are reported in Attachment C2, and provider termination counts are reported in Attachment C3.

1. Primary Care Providers (PCPs)

MCOs are required to assign 100 percent of non-dual members to a PCP within 5 business days of MCO enrollment. HHSC confirmed that all MCOs assign members to a PCP, and all adult members have access to at least one PCP and children to at least two age-appropriate PCPs within established mileage standards, as outlined in the following section of this report.

Across the STAR program statewide, the MCOs reported a total of 16,372 unique PCP providers, an increase of 235 from the prior quarter. The MCOs reported 12,842 unique PCP providers in the STAR+PLUS program statewide, an increase of 245 from the prior quarter.

2. Specialists (non-pharmacy)

Across the STAR program statewide, the MCOs reported a total of 52,964 unique specialty providers, an increase of 1,726 from the prior quarter. The MCOs reported 42,687 unique specialty providers in the STAR+PLUS program statewide, a decrease of 692 providers.

Aetna STAR in Bexar SDA reported a 45 percent increase in provider network specialist counts in SFQ2. HHSC is working with the plan to determine the cause of this increase, which may just

be a reporting error on the network file. If Aetna submitted an inaccurate network report, then HHSC will determine an appropriate remedy.

3. Provider Terminations

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in 2015 SFQ2. The MCOs reported a variety of reasons for provider termination, including: termination requested by provider, MCO terminated for cause, provider left group practice, and provider closed. Driscoll STAR, Molina STAR and STAR+PLUS, and Sendero STAR reported an increase in the number of terminated providers in SFQ2 due to review of network files to remove inactive or duplicated providers.

4. Pharmacy Providers

Across the STAR program statewide, the MCOs reported a total of 4,852 unique pharmacies, an increase of 60 pharmacies from the prior quarter. The MCOs reported 4,793 unique pharmacies in the STAR+PLUS program statewide, an increase of 96 pharmacies from the prior quarter. A few MCOs reported statewide pharmacy counts rather than counts limited to the SDA in SFQ2. All MCOs contract with the pharmacies outside the SDA to ensure members have access to a pharmacy if traveling outside the SDA.

5. Dental Program Provider Counts

In 2015 SFQ2, DentaQuest reported a total of 4,930 unique dental providers, an increase of 3 dental providers from the prior quarter. MCNA reported 4,290 unique dental providers, an increase of 234 dental providers from the prior quarter.

B. GEOACCESS

This subsection includes quarterly geoaccess information based on geomapping data provided by HHSC Strategic Decision Support (SDS) and self-reported by MCOs, in accordance with STC 39(a).

Attachments E, G and H show HHSC geomapping results by plan and SDA for the following provider types and populations:

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

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

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

For all STAR and STAR+PLUS service areas, the following benchmarks were applied for access to PCPs and specialists:

- 90 percent – access to at least one open panel PCP for adults and two open panel PCPs for children
- 90 percent – access to at least one of all other provider types for adults and children

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

1. Access to PCPs and ENTs

Geoaccess to PCPs and ENTs is reported on Attachments E and I. In SFQ2 across the state, the STAR and STAR+PLUS programs exceeded the State's 90 percent benchmarks for access to PCPs and ENTs.

The following MCOs failed to meet the access standard for children access to an ENT in 2015 SFQ2:

- Amerigroup STAR in MRSA West SDA
- FirstCare STAR in MRSA West SDA
- United STAR in Hidalgo and Jefferson SDAs
- Amerigroup STAR+PLUS in MRSA West
- United STAR+PLUS in Jefferson, MRSA Central, and MRSA Northeast SDAs

Amerigroup STAR and STAR+PLUS and FirstCare STAR failed to meet the access standard for ENT in MRSA West due to a shortage of ENT physicians enrolled with Texas Medicaid. Amerigroup submitted a special exception request which is pending approval from HHSC, so the plan may not be subject to remedy. HHSC approved a special exception request from FirstCare for SFQ2 and SFQ3 in 2015; the plan will not be subject to remedy. To minimize access to care issues, the plan assisted members with scheduling appointments and provided medical transportation when necessary. United failed to meet geoaccess standards due to inaccurate network files submitted to HHSC; HHSC is in the process of developing the appropriate remedy.

2. Access to Specialty Care

Attachment I shows the geoaccess measures by MCO for specialty care.

The following MCOs failed to meet the standards for children and/or adults accessing allergists/immunologist:

- Amerigroup STAR in MRSA West SDA
- FirstCare STAR in MRSA West SDA
- Superior STAR in MRSA West SDA
- Amerigroup STAR+PLUS in MRSA West SDA
- Cigna-HealthSpring STAR+PLUS in MRSA Northeast SDA
- Superior STAR+PLUS in MRSA West SDA
- United STAR+PLUS in MRSA Northeast SDA

Amerigroup submitted a special exception request which is pending approval from HHSC, so the plan may not be subject to remedy. Superior received approval from HHSC for a special exception request for SFQ2 through SFQ4 of 2015, and is attempting to recruit additional allergists and immunologists. FirstCare and Cigna-HealthSpring received approval for a special exception from HHSC for SFQ2 through SFQ3.Cigna-HealthSpring is attempting to recruit new providers, and Firstcare is always accepting new provider-credentialing applications. United failed to meet geoaccess standards due to inaccurate network files submitted to HHSC; HHSC is in the process of developing the appropriate remedy.

Amerigroup STAR+PLUS in MRSA West failed to meet additional access standards for specialty care, bulleted below. Amerigroup submitted a special exception request which is pending approval from HHSC, so the plan may not be subject to remedy.

- Access for children to an orthopedic surgeon
- Access for children to an outpatient behavioral health provider
- Access for adults to a gastroenterologist
- Access for adults to a pulmonologist

Molina STAR in Jefferson SDA failed to meet the access standards for access to an acute care hospital in SFQ2 by two percent. The plan is attempting to recruit providers to increase the network.

Superior STAR+PLUS in MRSA West failed to meet the geoaccess standard for adult access to gastroenterologist and pulmonologist. Superior received approval from HHSC for a special exception request for SFQ2 through SFQ4 of 2015.

3. Access to Pharmacy

Attachment G provides summaries of HHSC geomapping data by plan and SDA for pharmacies. For all STAR and STAR+PLUS service areas, the following benchmarks applied:

- 80 percent – access to a network pharmacy in urban counties within 2 miles (75 percent in STAR MRSAs)
- 75 percent – access to a network pharmacy in suburban counties within 5 miles (55 percent in STAR MRSAs)
- 90 percent – access to network pharmacy in rural counties within 15 miles
- 90 percent – access to a 24-hour pharmacy in all counties within 75 miles (only available on MCO self-reported data)

Certain areas continued to have deficiencies in meeting access standards in SFQ2. The greatest shortfalls are pharmacies in the MRSAs. It is important to note that 100 percent of members have access to mail order pharmacies. This is a particularly important accessibility benefit for members who require maintenance medications to manage chronic health conditions. It is also important 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.

4. Dental GeoMapping

Dental geomapping results are divided into eleven Texas regions. Within each region, HHSC generates a report on the percentage of members in urban and rural areas with access to main dentists, endodontists, oral surgeons, orthodontists, periodontists, and prosthodontists. Attachment H provides summaries of HHSC geomapping information for both dental plans and Attachment K provides geomapping from both dental plans.

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

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

In SFQ2, both DentaQuest and MCNA maintained mostly sufficient provider networks for main dentists in rural and urban counties as well as pediatric dentists statewide. Access to dental specialty providers is limited in some parts of Texas, as depicted in Attachment H. This is, in part, due to overall provider shortages in these areas. Both dental managed care organizations, known as DMOs, report continuing activities to monitor the State Licensing Board website and HHSC claims administrator website, and utilize other internet resources in an effort to identify potential recruitment opportunities. HHSC received and approved a special exceptions from DentaQuest for 2015 SFQ1 and SFQ2 and from MCNA for SFQ2.

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 service area, OON utilization should not exceed the following thresholds:

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

Attachment D details the OON utilization rates by program, MCO and SDA. The following plans exceeded OON utilization standards in SFQ2 of 2015:

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

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

- United STAR+PLUS in Harris and MRSA Central SDAs

Within the STAR and STAR+PLUS programs in 2015 SFQ2, OON utilization was generally higher in Dallas and Harris SDAs. This trend is due to strained contract negotiations between hospitals and MCOs. HHSC approved special consideration requests from MCOs listed above and none will be subject to remedy. The State will continue to monitor these plans, and will require corrective action or other remedies if appropriate. A description of the special consideration request process is detailed below.

Under certain circumstances, plans may request time-limited exemptions from the OON standards if the plans provide evidence warranting special consideration. In order to be granted an exemption the plan must demonstrate both that admissions or visits to a single OON facility account for 25 percent or more of the plan's admissions or visits in a reporting period; and the plan can demonstrate that it made good faith reasonable efforts to contract with an OON facility to no avail. If the state grants the special consideration, it removes the non-contracted provider from the plan's compliance calculations and recalculates the utilization rate. HHSC evaluates the recalculated OON rates to determine whether OON standards are met. MCOs with approved special considerations are not subject to remedies or assessed liquidated damages (LDs). Attachment D provides utilization data, including recalculated rates, by program, MCO, and SDA.

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

III. OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

This section addresses the quarterly requirements for STC 67 regarding outreach and other initiatives to ensure access to care. The Dental Stakeholder Update addresses STC 40(c), the Medicaid Managed Care Advisory Committee meeting update also addresses STC 65.

A. ENROLLMENT BROKER AND MCO ACTIVITIES

The state's Enrollment Broker, MAXIMUS, performs various outreach efforts to educate potential clients about their medical and dental enrollment options. During the 2015 D2 Demonstration period (January-March 2015), MAXIMUS sent 326,937 enrollment mailings to potential STAR and STAR+PLUS clients, and 218,080 mailings to potential Dental Program clients. MAXIMUS field staff completed 24,866 home visit attempts for these programs, and 89,695 phone call attempts. Additionally, MAXIMUS completed 2,134 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
- 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
- How to obtain transportation through the State's Medical Transportation Program

B. DENTAL STAKEHOLDER MEETING

In the absence of a dental director, HHSC is evaluating options for ongoing communication with dental stakeholders. HHSC staff continues to answer questions submitted to the State's dental stakeholder email box. HHSC also participated in a meeting with the Texas Dental Association and the DMOs on January 10, 2015 to discuss provider concerns and issues. The topics discussed included: main dental home assignments, dental quality initiatives, and policy issues and updates.

C. MEDICAID MANAGED CARE ADVISORY COMMITTEE

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

The SMMC did not meet during SFQ2 2015. The next meeting took place on April 29, 2015.

D. INDEPENDENT CONSUMER SUPPORTS SYSTEM

HHSC submitted a plan to CMS on May 1, 2014, describing the structure and operation of the Independent Consumer Supports System (ICSS) that aligns with the core elements provided in STC 20. The Texas ICSS consists of the HHSC Medicaid/CHIP Division, the Office of the Ombudsman, the State managed Enrollment Broker (EB, MAXIMUS), and community support from the Aging and Disability Resource Centers (ADRCs). HHSC and CMS held a phone call on January 6, 2015, to discuss the ICSS plan and in response to that discussion HHSC resubmitted the report to CMS with additional information on February 9, 2015. HHSC will provide relevant updates regarding ICSS in this section of the report each quarter.

1. Office of the Ombudsman

Within the Office of the Ombudsman, the Medicaid Managed Care Helpline (MMCH) team is undergoing an expansion to 17 positions to ensure consumers are receiving the support they need. In addition to the existing Manager and Team Lead, the number of Advocates answering the toll-free line has been increased from eight to ten. Two additional positions have been authorized to act as in-house escalation positions to work on cases needing additional follow-up. An additional position has been authorized to serve as a planning and training coordinator and another two positions are planned to focus on coordination with ICSS components within the HHS agencies, as well as with community partners.

2. Aging and Disability Resource Center

The statewide expansion of the Aging and Disability Resource Center (ADRC) Program was completed in SFQ2. Statewide ADRC training webinars have been implemented each month with a focus on standardized information and referral processes regarding a variety of target populations. To date, trainings have included information on access to long term services and supports with a targeted focus on veterans, children with special needs and family caregivers. A number of ADRC providers and local partner networks have also engaged in cross-training activities related to local support resources, managed care organizations, and enrollment broker roles. These ADRCs have knowledge of the appropriate referral for consumer supports, including the enrollment broker and Office of the Ombudsman and most have direct relationships with specific service coordinators from managed care organizations in their region. Some have managed care representatives present at monthly ADRC steering committee meetings.

Most ADRCs report they have been trained about the roles and responsibilities of the enrollment broker, but have not had formal training about the roles and responsibilities of the Office of the Ombudsman and referral processes for such. In the upcoming quarter, state level ADRC program staff will work to schedule a statewide Office of the Ombudsman webinar for ADRCs to ensure

local ADRCs understand the appropriate resources and referral processes within the independent consumer support system.

The ADRC toll-free number was successfully launched in January 2015. Some ADRCs report calls regarding access to Medicaid services, access to a service coordinator, or concerns about service delivery. State level ADRC staff, in coordination with the Department of Aging and Disability, Access and Intake staff, is developing a matrix of toll-free numbers for consumers based on their individual needs. A workgroup will develop uniform language to be shared across access points. Enrollment Broker and Office of Ombudsman staff are providing input to these revisions and referral processes to ensure statewide consumer experience across appropriate access points.

E. HHSC MANAGED CARE INITIATIVES

HHSC representatives traveled extensively across the state to meet with providers and provider associations, as well as clients and family members, advocacy organizations, and community groups to present on managed care and the upcoming initiatives. HHSC hosted provider trainings across the state December through February 2015 for providers affected by the nursing facility transition to managed care, roll out of Dual Demonstration, and implementation of CFC. MCO representatives were on hand at all of these meetings to present and answer questions.

The Enrollment Broker held enrollment events in nursing facilities across the state November 2014 – February 2015 for residents newly eligible for STAR+PLUS starting March 1, 2015.

HHSC held various trainings, meetings, educational and outreach events related to the roll out of Dual Demonstration this quarter. In the months of December 2014 through February 2015, HHSC held eight provider trainings and seven stakeholder meetings across the state. In addition, the enrollment broker (MAXIMUS) has been conducting outreach and educational events to educate clients and family members on enrollment. The State Health Insurance Assistance Programs (SHIP)s and the Area Agency on Aging (AAA) have been working with HHSC, and the SHIPs are listed on some of the letters MAXIMUS sends out as a resource. The AAAs are hosting consumer events with MAXIMUS, and outreach staff have coordinated events with community organizations. More information can be found at the Texas Medicaid Events Website: http://www.texasmedicaidevents.com/Tx_EngCalendarPage.asp?Area=bexar.

In preparation for the implementation of CFC, HHSC held 12 provider trainings across the state between January and February 2015 to educate providers about managed care. In addition, HHSC held 13 stakeholder meetings between December 2014 and February 2015. More information can be found at the Community First Choice website: http://www.hhsc.state.tx.us/medicaid/managed-care/community-first-choice/

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

IV. COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

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

The state continues to conduct the quarterly MCO encounter financial reconciliation process for 2015 SFQ2. The state will contact each plan that did not achieve the financial reconciliation threshold, and advise them of the necessary steps to achieve contract compliance and, ultimately, certification.

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

This section addresses STC 67, 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 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 FQHC's 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 then non-suited TCHP, but continues to maintain its claims against HHSC. The case remains pending.

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.

Dr. Essa Kawaja, DDS; Summit Dental Center, Dental Smiles; Dr. Anila Shah, DDS, PA. v. HHSC, Suehs, Delta Dental, Dentaquest USA, and Managed Care of North America. Filed on February 28, 2012, in state district court in Travis County. Dental providers complained of the default enrollment procedures for Medicaid managed care clients that do not choose a provider. They asked the court to restrain HHSC and the Medicaid DMOs from implementing the default enrollment procedures and to declare those procedures illegal. HHSC voluntarily delayed the dental home requirement until May 31, 2012, to allow clients more time to notify their dental plan of their preferred dentist without any disruption in service. Plaintiffs withdrew their request for a temporary restraining order following HHSC's action. The Office of the Attorney General has filed a general denial and a plea to the jurisdiction. The case has been dormant since June 2012, and was placed on the DWOP (dismissal for want of prosecution)

docket, but remains pending at this time. Of all the lawsuits filed in 2011-2012 challenging HHSC's expansion of the Medicaid managed care delivery model, *Kawaja* is the sole case still pending. All others have been dismissed or resolved.

Filed in 1993, *Frew, et al. v. Janek, 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 Health and Human Services Commission (HHSC) and the 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 court vacated two of the eleven corrective action orders: (1) Checkup 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. Most recently, on January 20, 2015, the U.S. district court vacated the correction 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 both recipients and other providers.

C. NEW ISSUES

HHSC has not identified any new issues in the relevant subject matter sections of this report, other than those already reported in previous sections. There were no issues outside of the

general categories typically reported and HHSC does not anticipate any significant issues or activities in the near future that affect healthcare delivery.

D. CLAIMS SUMMARY

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

1. Claims Adjudication

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

- 98 percent must be adjudicated within 30 days;
- 98 percent of appealed claims must be adjudicated within 30 days; and
- 99 percent must be adjudicated within 90 days.
- 98 percent of pharmacy claims must be adjudicated within 18 or 21 days for electronic and paper claims, respectively.

Attachment V is a summary of the health and dental plans' 2015 SFQ1 and SFQ2 claims adjudication results. For these quarters, STAR and STAR+PLUS MCOs reported results for acute care, behavioral health, vision services, and pharmacy claims. Additionally, STAR+PLUS MCOs also reported results for long-term services and supports claims. Dental plans reported results for all dental claims. Almost all MCOs met the claims processing standards with a few exceptions listed below. The following plans did not meet the claims processing standards in 2015 SFQ1 and SFQ2 and HHSC is in the process of applying appropriate remedies:

- Aetna STAR in Bexar and Tarrant SDAs did not meet the standard for processing clean acute care claims. Aetna dedicated additional staff to resolve claims, provided additional training and expanded oversight of claims processing activities.
- BCBS STAR in Travis SDA missed the processing standard for clean behavioral health claims by a fraction of one percent.
- Community Health Choice STAR in Harris SDA did not meet processing standards for appealed behavioral health claims for the second quarter in a row.
- Cook Children's STAR in Tarrant SDA did not meet processing standards for appealed behavioral health claims and clean vision services claims due to a system issue the plan is working to correct. HHSC will monitor progress of the plan to resolve issue.
- Scott and White STAR in MRSA Central did not meet processing standards for appealed acute care claims in 2015 SFQ1. Scott and White received an increase in the number of

appeals due to a change in payment delivery for participating providers. The plan improved internal processes and met all claims processing standards in 2015 SFQ2.

- Sendero STAR in Travis SDA did not meet processing standards for appealed acute care claims. The plan received 8 appealed claims in SFQ2 and failed to resolve 1 claim within 30 days due to staff error. Sendero is working to ensure the issue does not continue and is closely monitoring claim processing activities.
- Seton STAR in Travis SDA did not meet processing standards for appealed acute care claims by less than one percent.
- Superior STAR in Bexar and Travis SDAs did not meet the processing standards for appealed behavioral health claims due to Superior claim processing staff errors. Superior provided additional training for all staff in order to improve processing.
- United STAR in Jefferson SDA did not meet processing standards for clean behavioral health claims. HHSC is in the process of developing an appropriate remedy.
- Amerigroup STAR+PLUS did not meet the standard for processing appealed behavioral health claims in Jefferson and Tarrant SDAs. HHSC considers the plan to be in compliance in Harris SDA since the plan only missed the standard by less than one half of a percent.
- Cigna HealthSpring STAR+PLUS in Hidalgo, MRSA Northeast, and Tarrant SDAs did not meet standards for processing acute, behavioral health, vision, and long term services and supports claims. HHSC placed the plan on a corrective action plan in SFQ1 and the plan will be subject to liquidated damages. Cigna-HealthSpring implemented several claims adjudication initiatives, including additional staff, to improve claim processing operations, but the claim processing issues persisted in SFQ2.
- Molina STAR+PLUS in Bexar SDA did not meet standards for processing appealed acute claims.
- United STAR+PLUS in Jefferson, MRSA Northeast, and Nueces SDAs did not meet standards for processing behavioral health. HHSC approved a corrective action plan from the MCO on March 6, 2015 in order to correct the claim processing issue.

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

Both dental plans met the claim adjudication standards for clean claims in 2015 SFQ1 and SFQ2.

2. Provider Fraud and Abuse

The state's managed care contracts require health and dental plans to form special investigative units that refer suspected cases of fraud, waste, or abuse to the HHSC Office of Inspector General (OIG). Attachment R is a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period, 2015 SFQ1 and SFQ2.

In SFQ1 and SFQ2, MCOs forwarded 41 suspected cases of fraud, waste, or abuse to the OIG. More than half of these referrals related to non-appropriate billing and billing for services not rendered. OIG returned 16 of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for 14 cases received. The remaining cases were referred to federal OIG for investigation, or the appropriate licensing board. Dental plans forwarded 31 suspected cases of fraud, waste, or abuse to the OIG. Among the most common outcomes, most of the cases related to inappropriate billing and program non-compliance. OIG issued a full scale investigation or transferred information to existing full scale cases for 18 of the 31 cases. The remaining cases were returned to the MCO and one was closed upon receipt.

VI. ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

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

1. Managed Care Issues

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

2. Litigation

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

3. Other

The state of Texas legislative session began in January 2015 and will end in summer 2015. During this quarter, HHSC staff has been analyzing bills to determine potential impact on STAR, STAR+PLUS, and Dental managed care programs.

VII. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

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

There were no significant development/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality report for 2015 SFQ2.

VIII. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements in STC regarding eligible member month participants, in compliance with STC 53.

Eligibility Groups Used in Budget Neutrality Calculations (2015 D2)

Eligibility Group	Month 1 (Jan 2015)	Month 2 (Feb 2015)	Month 3 (Mar 2015)	Total for Quarter Ending Mar 2015
Adults	287,386	288,058	288,574	864,018
Children	2,647,031	2,636,821	2,628,826	7,912,677
AMR	358,373	358,369	358,522	1,075,264
Disabled	426,252	428,101	427,800	1,282,152

Eligibility Groups Not Used in Budget Neutrality Calculations (2015 D2)

Eligibility Group	Month 1 (Jan 2015)	Month 2 (Feb 2015)	Month 3 (Mar 2015)	Total for Quarter Ending Mar 2015
Adults in MRSA	-	-	-	-
Foster Care	33,188	33,157	33,003	99,348
Medically Needy	146	143	143	432
CHIP-Funded	258,354	266,194	266,709	791,257
Adoption Subsidy	44,350	44,576	44,804	133,730
STAR+PLUS 217-Like HCBS	16,826	16,826	15,884	49,536

IX. CONSUMER ISSUES

This section addresses quarterly reporting requirements in STCs 22 and 39(a) regarding complaints and calls to HHSC Health Plan Management (HPM) staff and the Office of the Ombudsman's Medicaid Managed Care Helpline (MMCH). It also includes trends discovered and steps taken to resolve complaints and prevent future occurrences.

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

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

A. HOTLINE CALL VOLUME AND PERFORMANCE

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

Calls to the MCO member hotlines increased by approximately 7 percent in 2015 SFQ2. Calls to the MCO provider hotlines decreased by three percent. Attachments M detail the total calls received as well as performance standards for all MCOs and DMOs. In the Dental Program, calls to the member and provider hotlines decreased by approximately 7 percent in SFQ2.

The following table shows the number of hotline calls received per 1000 members in the last four quarters. The rate of member hotline calls received per 1000 members decreased in 2015 SFQ2 across most plans.

Member Hotline Calls Received per 1000 Members (2014 SFQ3 - 2015 SFQ2)

MCO	Member Hotline per 1000 Members			
	14 Q3	14 Q4	15 Q1	15 Q2
Aetna*	510	483	492	**448**
Amerigroup*	187	196	194	**178**
BCBS*	290	273	260	**255**
CHC*	192	201	183	**181**
Christus*	315	301	298	**263**
Cigna-HealthSpring	920	1,025	911	**762**
Community 1st*	108	107	106	**110**
Cook Children's*	203	176	187	**174**
DentaQuest	82	89	77	**78**
Driscoll*	149	156	161	**152**
El Paso 1st*	189	175	172	**167**
FirstCare*	174	165	142	**134**
MCNA	107	118	102	**86**
Molina*	317	314	325	**334**
Parkland*	232	211	220	**226**
Scott & White	322	379	346	**327**
Sendero*	239	282	202	**217**
Seton*	224	466	431	**345**
Superior*	230	227	232	**217**
Texas Children's*	102	91	85	**96**
United*	405	412	478	**437**
Statewide (excludes Dental Program)	**224**	**224**	**231**	**219**
*Enrollment and Hotline data includes CHIP program				

Most MCOs and DMOs met the following hotline performance in 2015 SFQ2:

- 99 percent of all calls must be answered by the fourth ring
- ≤ 1 percent busy signal rate for all calls
- 80 percent of all calls must be answered by a live person within 30 seconds
- ≤ 7 percent call abandonment rate

- ≤ 2 minute average hold time

The following MCOs failed to meet the standards listed above. HHSC staff is in the process of developing appropriate remedies for the following MCOs.

- Aetna failed to meet the requirement for the percent of member and behavioral health hotline calls answered by the fourth ring.
- Molina failed to meet the requirement for the percent of member hotline calls answered by a live person within 30 seconds and the percent of provider hotline calls with a busy signal.
- Parkland failed to meet the requirement for the percent of member hotline calls answered by a live person within 30 seconds.
- Scott and White failed to meet the requirement for percent of behavioral health calls abandoned.

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.

1. STAR and STAR+PLUS

The total number of complaints and appeals received by plans increased from 2015 SFQ1 to 2015 SFQ2, as shown in the figures below. STAR plans collectively reported 754 member complaints, 1,435 member appeals, and 199 provider complaints in SFQ2. STAR+PLUS plans resolved 1,176 member complaints, 1,305 member appeals, and 265 provider complaints in SFQ2. Amerigroup, Superior, United, and Molina make up more than 65 percent of STAR and STAR+PLUS member complaints. The STAR+PLUS MCOs received significantly more member complaints and appeals per 1000 members than the STAR MCOs due to the complicated medical needs of the STAR+PLUS population.

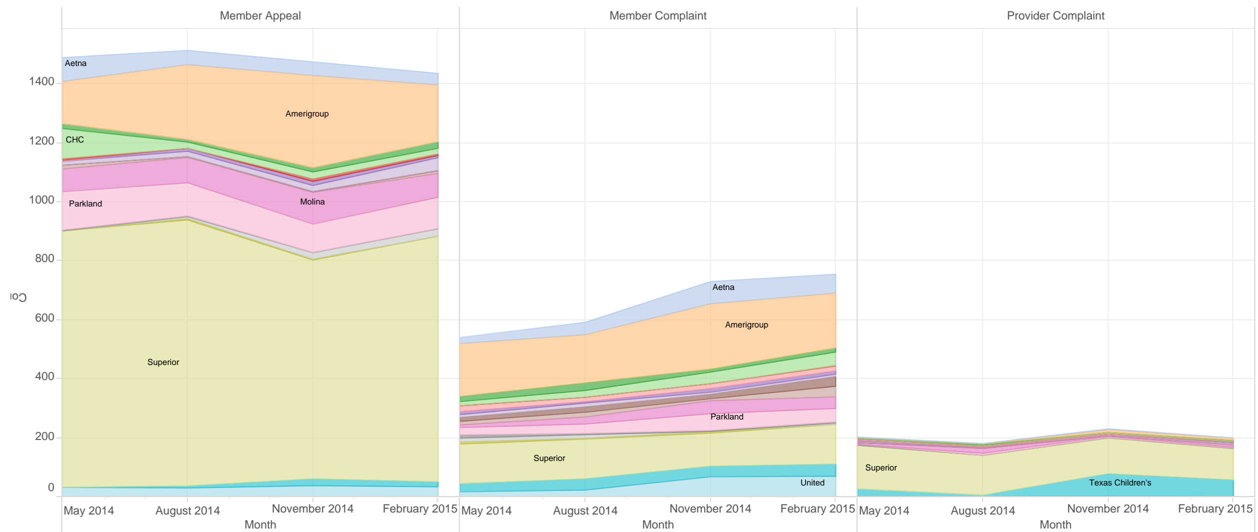
As reported in the prior 1115 quarterly report to CMS, Aetna reported an increase in the number of miscellaneous member complaints due to providers balance billing members. Most of the complaints had to do with out-of-network providers. Aetna staff educated all in and out-of-network providers that improperly billed Medicaid members on policies related to billing Medicaid members. In addition, Aetna staff advises members, when they are not responsible for payment of claims, to submit copies of correspondence from the provider, and the plan follows up with the provider directly.

FirstCare STAR in Lubbock SDA reported an increased number of member complaints in SFQ2 due to the classification of calls received through member calls. In the past, FirstCare staff did not categorize member issues resolved during the initial call as a complaint; however, the plan began capturing any expression of dissatisfaction as a complaint in SFQ2.

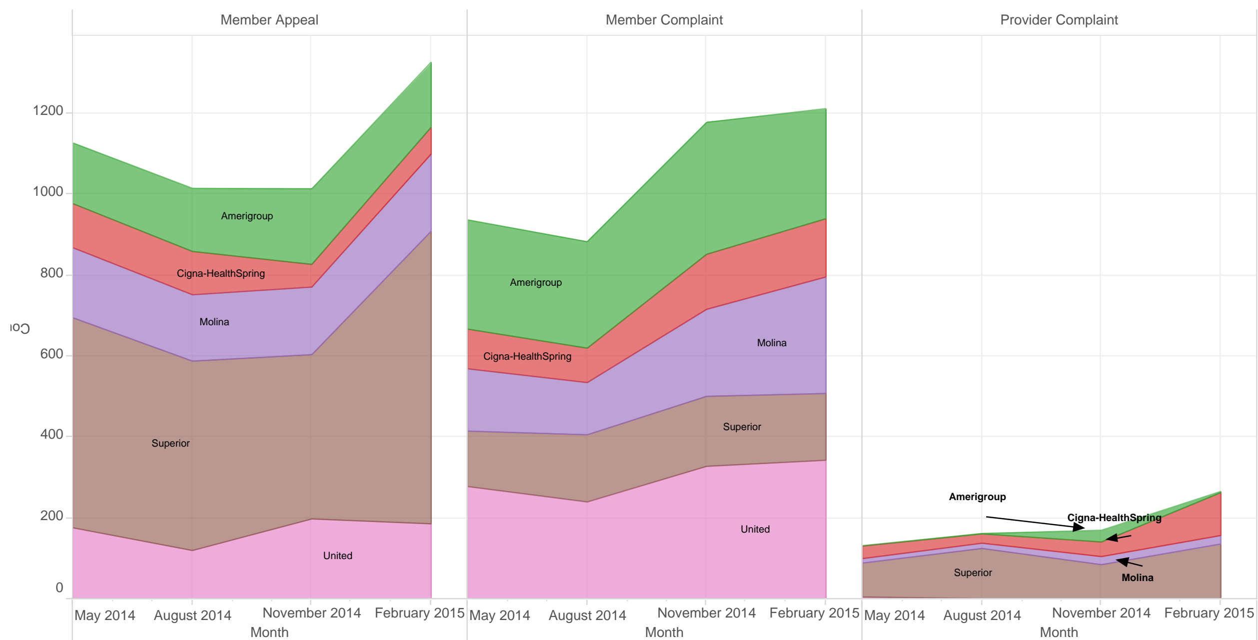
Superior STAR and STAR+PLUS in Bexar SDA and STAR in Travis SDA received an increased number of member appeals in SFQ2 from prior quarters. HHSC is working with the plan to determine the cause.

Cigna-HealthSpring received an increase in the number of provider complaints in SFQ2, due to claim processing issues reported in Section V of this report. HHSC approved a corrective action plan from the plan to address the claim processing issues.

Complaints and Appeals Received by STAR MCOs (2014 SFQ3 – 2015 SFQ2)



Complaints and Appeals Received by STAR+PLUS MCOs (2014 SFQ3 – 2015 SFQ2)



The state's managed care contracts require plans to track and monitor the number of complaints and appeals that are resolved within 30 days of receipt and require 98 percent compliance with this benchmark. The following MCOs failed to meet the standard for percent of member complaints and appeals or provider complaints resolved within 30 days in SFQ2. HHSC staff is in the process of developing appropriate remedies for the following MCOs.

- Amerigroup STAR failed to meet the standard for member appeals in Lubbock and MRSA West SDAs and the plan failed to meet the standard for provider complaints in Harris and MRSA Northeast SDAs.
- Driscoll STAR in Hidalgo SDA failed to meet the standard for member appeals.
- Parkland STAR in Dallas SDA failed to meet the standard for member complaints.
- Superior STAR in Bexar and Hidalgo SDAs failed to meet the standard for provider complaints.
- Amerigroup STAR+PLUS in Harris SDA failed to meet the standard for provider complaints.
- Superior STAR+PLUS in Bexar and Nueces SDAs failed to meet the standard for member for complaints.
- United STAR+PLUS in Travis SDA failed to meet the standard for member appeals.

1. Dental Program

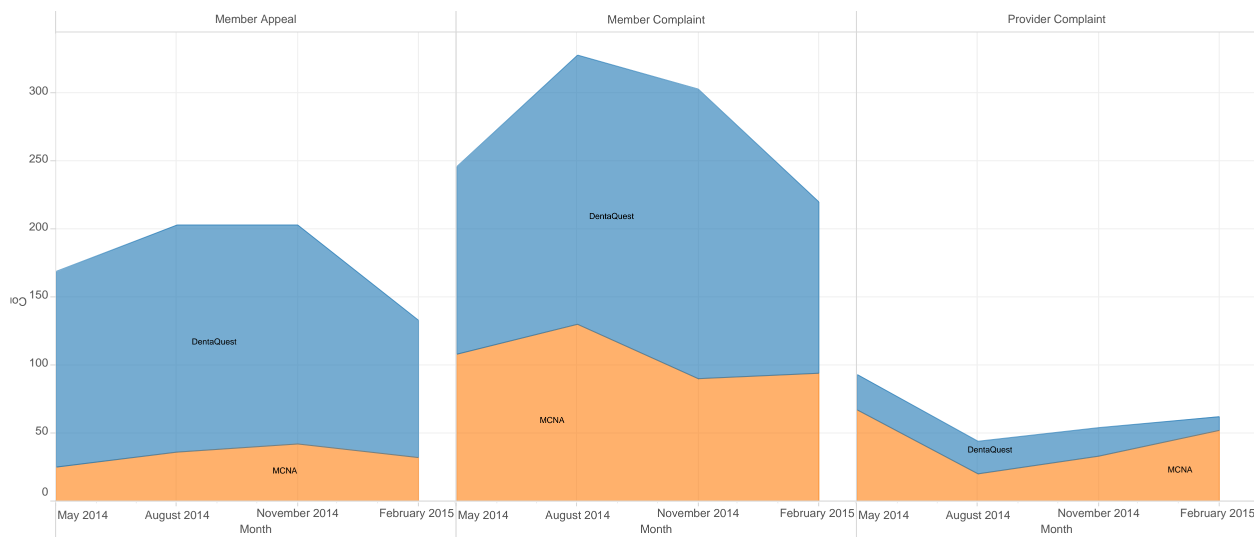
Between 15SFQ1 and 15SFQ2, dental member complaints decreased by 27 percent, member appeals decreased by 34 percent, and provider complaints increased by 14 percent. The most common member complaint to the dental plans involved either dissatisfaction with the quality of care provided by a treating dental provider, or access to or availability of services. Member appeals primarily related to dental plans' utilization review or management, such as the denial of prior authorization requests. Providers generally complained about claims processing or plan administration.

Complaints and appeals are reported in aggregate for each statewide dental plan. Each MCO has over one million members enrolled across the state; therefore, the changes in complaints and appeals represent a very small fluctuation as a percentage of enrolled members.

	Member Complaints per 1000 Members				**Member Appeals per 1000 Members**			
	14 Q3	**14 Q4**	**15 Q1**	**15 Q2**	**14 Q3**	**14 Q4**	**15 Q1**	**15 Q1**
DentaQuest	0.10	0.13	0.13	0.08	0.10	0.11	0.10	0.06
MCNA	0.10	0.11	0.07	0.07	0.02	0.03	0.03	0.02
Dental Program	**0.10**	**0.12**	**0.12**	**0.08**	**0.07**	**0.07**	**0.07**	**0.05**

MCNA and DentaQuest met all performance standards for the timely resolution of complaints and appeals in SFQ2.

Complaints and Appeals Received by DMOs (2014 SFQ3 – 2015 SFQ2)



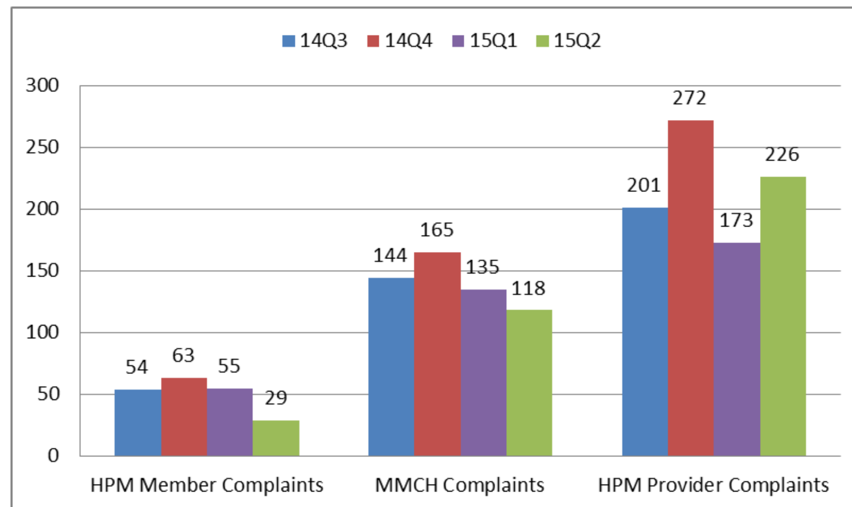
C. COMPLAINTS RECEIVED BY THE STATE

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

1. STAR

In the STAR program, the number of member complaints received by HPM and MMCH, overall, decreased by 47 and 12 percent, respectively. The most common member complaints received by HPM and MMCH were issues with verifying eligibility or enrollment while at pharmacies and access to care. The number of provider complaints received by HPM increased by 30 percent in 2015 SFQ2. The most common issue type of provider complaints received by HPM was denial of claim.

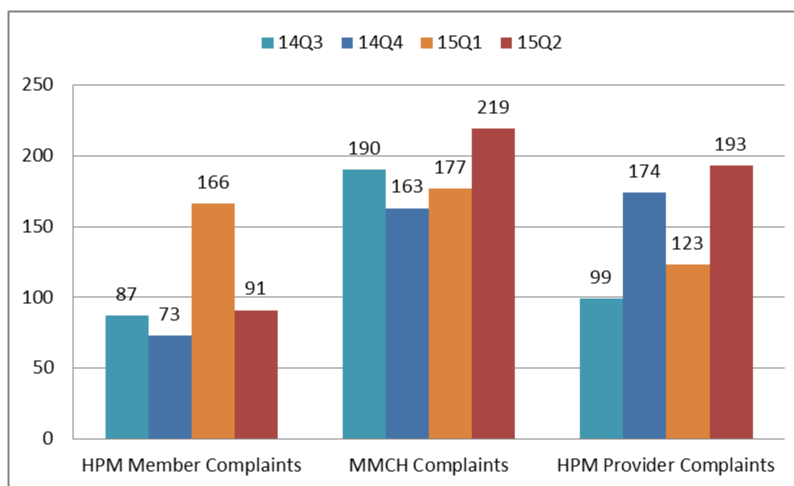
Complaints to the State Regarding STAR (SFY2014 - SFY2015)



2. STAR+PLUS

Across the STAR+PLUS program, the number of member complaints received by MMCH increased by 23 percent in SFQ2 and the member complaints received by HPM decreased by 45 percent. The most common issue type of member complaints received by MMCH and HPM was access to care and access to long term services and supports. The number of provider complaints increased by 57 percent in 2015 SFQ2.

Complaints to the State Regarding STAR+PLUS (SFY2014 - SFY2015)



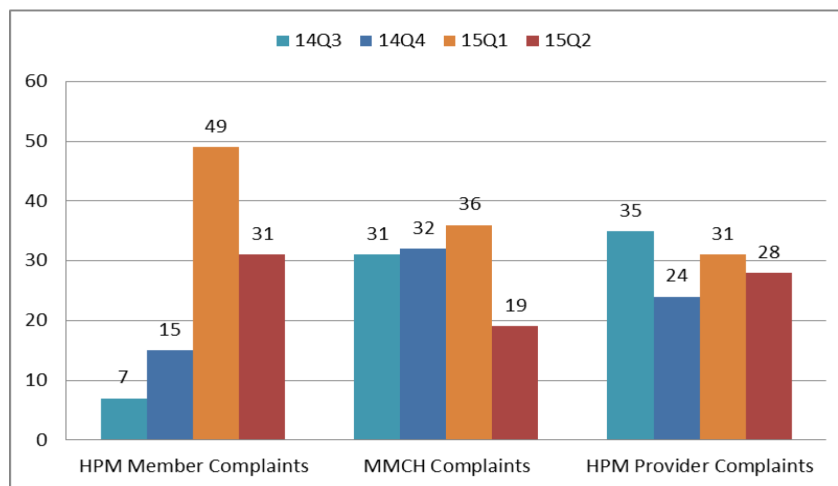
The following paragraph addresses STC 22. In order to monitor performance and quality during the STAR+PLUS expansion to the MRSAs, HHSC tracked complaints received from members and providers in the STAR+PLUS MRSAs. Of the total of 219 STAR+PLUS member complaints received by HPM, 26 came from members in the MRSAs. Of the total 91

STAR+PLUS complaints received by MMCH, 55 came from members in the MRSAs. Of the 193 provider complaints received in STAR+PLUS, 23 had to do with the MRSAs. The most common provider complaint issue had to do with denied claims.

3. Dental Program

Across the Dental Program, the number of member complaints received by MMCH and HPM decreased by 47 and 36 percent, respectively in 2015 SFQ2. The most common member complaint issue types about the Dental Program had to do with incorrect eligibility or enrollment information. The most common provider complaint issue type received had to do with denied claims. Provider complaints decreased by 10 percent from 2015 SFQ1 to 2015 SFQ2.

Complaints to the State Regarding the Dental Program (2014 SFQ3 - 2015 SFQ2)



X. QUALITY ASSURANCE/MONITORING ACTIVITY

HHSC releases MCO report cards to help members of STAR, STAR+PLUS, and CHIP identify and select a MCO.

During SFQ2, HHSC continued the process of updating the report cards for 2015. Similar to the last round of report cards, a separate report card will be developed for each service area to provide information on the performance of each MCO with respect to outcome and process measures. Results will allow members to easily compare MCOs on quality domains of interest to them. The 2015 reports cards will be made available to members on the HHSC website in late fall and will be included in the enrollment packets sent to all newly eligible members. The measures will continue to be reviewed and updated annually.

In SFQ2, HHSC continued revising its performance improvement project (PIP) process in an effort to improve the quality of MCO PIPs. Recent changes include updating the PIP plan template, final PIP report template, scoring criteria and data submission guidelines.

During SFQ2, HHSC continued work with our External Quality Review Organization (EQRO) to find ways to enhance the 2015 Dental Pay-For-Quality (P4Q) program. The Texas Dental P4Q Program is based on the concept of incremental improvement where each dental plan is incentivized to improve its own quality performance each year and is evaluated based on its success in achieving such improvement. By evaluating each plan based on its own performance, both plans have an opportunity to succeed in the program. HHSC held a meeting in February with the dental plans to discuss concerns and questions regarding the Dental Pay-For-Quality program. HHSC will consider the dental plans' concerns to make future modifications to the program.

During SFQ2, HHSC finalized the results of the 2013 At-Risk/Quality Challenge. The At-Risk/Quality Challenge stipulates that up to five percent of an MCO's capitation can be recouped based on performance in quality measures. This initiative gives HHSC an opportunity to focus MCO performance on specific measures that foster achievement of HHSC program goals and objectives. Each MCO has the opportunity to achieve performance levels that enable it to receive the full at-risk amount. However, should an MCO not achieve those performance levels, HHSC will recoup the appropriate portion of the five percent at-risk amount. Some performance indicators are standard across the managed care programs while others may apply to a specific program. Plans received notification that they either owed money to the state due to poor performance or that they would receive an award for high performance.

XI. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 67, regarding evaluation activities and issues.

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from January 1, 2015 through March 31, 2015.

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; and

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

The Program evaluation will examine the implementation and impact of the Program through a set of quarterly and annual performance measures throughout the demonstration period (December 12, 2011 through September 30, 2016). The principal focus of the demonstration evaluation will be on obtaining and monitoring data on performance measures for short-term (process measures) and intermediate (health outcomes) of the Program. The performance measures will be used to assess the extent to which the Program accomplishes its goals, track changes from year to year, and identify opportunities for improvement.

This report identifies:

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

B. SUMMARY OF EVALUATION ACTIVITIES

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

1. HHSC SDS and Texas A&M attended monthly meetings and continued discussions regarding evaluation activities, including data collection, data requests, analysis, and preliminary results.
2. HHSC SDS and Texas A&M corresponded regarding the Primary/Behavioral Healthcare Integration case study scope of work and survey instruments.
3. HHSC SDS and Texas A&M communicated on the ongoing development of the interim report.
4. HHSC SDS and HHSC Waiver team provided feedback to Texas A&M on their draft interim report on RHP Stakeholder Survey 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 continued communication with HHSC Waiver team to discuss roles/responsibilities of learning collaborative, updates on data access, and identifying external evaluation partners who express an interest in collaborating on the evaluation of the demonstration.
3. HHSC SDS attended Regional Healthcare Partnership (RHP) anchor calls.

4. HHSC recruitment and selection of a Research Specialist V candidate is ongoing. A candidate was selected but declined the offer. The position has been reposted and applications are being accepted.
5. HHSC SDS evaluation staff attended the webinar entitled "All State SOTA Call – Medicaid Section 1115 Demonstration Evaluations: Introduction to Performance Assessment & Evaluation," in part led by Dr. Carol Irvin of Mathematica, Inc. on March 5, 2015. HHSC SDS evaluation staff also attended a follow-up conference call led by Dr. Irvin on March 12, 2015 that provided participants the opportunity to comment on the webinar.

Intervention I

1. HHSC SDS continued to document an Intervention I evaluation plan protocol which includes stratification methodology.
2. HHSC SDS continued to identify and collect baseline data for Intervention I.
    a. Fee-for-service claims and Managed Care encounters
    b. Eligibility files
3. HHSC Medicaid/CHIP modified the contract with the EQRO, the Institute for Child Health Policy (ICHP), to provide HHSC SDS with the data necessary to leverage qualitative data captured through the Consumer Assessment of Health Providers and Systems (CAHPS) surveys and Healthcare Effectiveness Data and Information Set (HEDIS) measures for waiver evaluation activities. The results of this analysis will be included in the final evaluation report due to CMS in January 2017.

Intervention II

1. A formal research proposal was approved in August 2014 and the Meadows Mental Health Policy Institute has provided the IGT funds for Texas A&M researchers to evaluate DSRIP projects integrating primary care into behavioral health settings for adults with severe and persistent mental illness (SPMI). HHSC is currently amending the contract with Texas A&M to include this new scope of work.
2. HHSC SDS continued categorizing the community needs identified in the RHP community needs assessment for inclusion in the interim report due to CMS on October 1, 2015. This analysis will allow HHSC to summarize statewide community needs. HHSC also categorized the community needs addressed by individual DSRIP projects. This information will allow HHSC to summarize which community needs the projects are addressing.
3. HHSC SDS reviewed and provided feedback to Texas A&M on their abstracts related to the 1115 waiver evaluation for the AcademyHealth Annual Research Meeting to be held in Minneapolis, MN on June 14-16, 2015.
4. HHSC SDS reviewed and provided feedback to Texas A&M on draft sections of evaluation goals 6-11 of the interim report.

5. HHSC provided feedback to Texas A&M on the initial development of and logistics for the 2015 External Evaluator's Meeting to take place in Austin on April 23-24, 2015.
6. HHSC SDS evaluation staff attended the Behavioral Health Integration Advisory Committee meeting on March 11, 2015.

Texas A&M Evaluation Activities: Intervention II

Evaluation Goal 5

1. Texas A&M received approval of outline for interim report.
2. Texas A&M continued work related to the interim report.

Evaluation Goal 6-8

1. Wave 1 phone surveys for Site 03 and 07 were completed. As of March 31, 2015, 80 people from Site 03 & Site 07 had participated.
2. Preliminary analyses of wave 1 patient phone survey data began (e.g., confirmatory factor analyses).
3. Fourteen professionals from 11 sites were interviewed in follow-up phone calls.
4. Coding for the qualitative interview data continued.
5. The draft interim report for EG 6-8 was prepared and submitted to the HHSC for comment.

Evaluation Goal 9

1. Texas A&M finalized data analysis for each RHP. Data analysis focused on examining changes in interorganizational ties from prior to implementation of the Waiver to DY2.
2. Texas A&M drafted an interim report and submitted it to HHSC for review on March 24, 2015.
3. Texas A&M submitted an abstract on EG 9 results to the AcademyHealth Annual Research Meeting, and it was accepted for a poster presentation in June 2015.

Evaluation Goal 10-11

1. Texas A&M drafted an interim report in preparation for sharing with HHSC on January 16, 2015.
2. Texas A&M continued work on the final technical report, incorporating HHSC comments from the interim report draft.
3. Texas A&M began evaluating elements of the learning collaboratives in each RHP. A summary of this review will be incorporated into the final interim report.
4. Texas A&M submitted an abstract on EG 10-11 results to the AcademyHealth Annual Research Meeting, and it was accepted for a poster presentation in June 2015.

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

1. All ten total site visits were completed by January 2015. These visits included a total of 63 staff interviews and 64 focus group participants.
2. Data collected during these visits were prepared for analysis. Analysis of the qualitative data are in process.

Challenges or Issues Encountered

1. Dr. Wells's transition from the Texas A&M School of Public Health to the University of Texas School of Public Health presented a challenge in maintaining leadership continuity, which she and Drs. Ohsfeldt and Kum have managed through close cooperation, with Dr. Ohsfeldt now serving as overall PI and Dr. Wells as co-PI and site PI for EG 6-8 and the primary-mental health integration project. During this time, Dr. Wells continued to spend two days per week at A&M meeting with project team members.
2. Due to unsatisfactory performance by research staff, Dr. Ohsfeldt assumed leadership of EG 5. Dr. Ohsfeldt is an accomplished methodologist with substantial claims-based analysis experience.

C. ACTIVITIES PLANNED IN NEXT QUARTER

1. HHSC SDS will attend project meetings and monthly CMS calls, as well as Regional Healthcare Partnership (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. HHSC SDS will continue to provide feedback to Texas A&M on the ongoing development of those sections of the interim report related to Intervention II.
4. HHSC SDS, HHSC Waiver Operations, the Meadows Mental Health Policy Institute, and UT Austin will continue to collaborate and provide feedback on the behavioral health project.
5. HHSC SDS will provide final feedback on draft presentations and logistics for the External Advisor's Meeting on April 23-24, 2015.
6. HHSC SDS, HHSC Waiver Operations, and HHSC Rate Analysis personnel plan to attend the External Evaluator's Meeting on April 23-24, 2015 in Austin, TX hosted by Texas A&M.
7. HHSC SDS will continue to draft and route the interim evaluation report due to CMS on October 1, 2015.

Intervention I

1. HHSC SDS will continue to gather baseline data for Intervention I.

2. HHSC SDS will continue to develop Intervention I evaluation plan protocol which includes stratification methodology for inclusion.
3. HHSC SDS will continue to develop those sections of the interim report related to Intervention I, as well as the report overall.

Intervention II

1. Texas A&M will host the April 23-24, 2015, External Advisors' Meeting in Austin, Texas.
2. The final interim report for evaluation goals 5-11 will be submitted to the HHSC.
3. A draft outline of the interim report for evaluation goal 5 will be modified based upon input from HHSC SDS, and the limitation of only DY1 data available for analysis.
4. Texas A&M will modify the evaluation goal 5 evaluation plan to accommodate the data availability change, and submit the intro and methods for the interim report to the HHSC SDS team.
5. Follow-up phone interviews (1-year post original data collection) of key informants at each site will continue.
6. Texas A&M will initiate qualitative coding of case study data.
7. Texas A&M will calculate descriptive statistics from patient phone survey data as well as the Relational Coordination portion of the professional interviews.
8. Data collection for wave 2 of the patient telephone surveys will continue.
9. Data analyses on the inter-organizational network survey will continue and be finalized.
10. Texas A&M will complete follow-up phone calls with key informants from the remaining four sites.
11. Texas A&M will present posters on evaluation goals 9-11 at AcademyHealth Annual Research Meeting in Minneapolis in June 2015.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

1. A draft interim report is to be completed in April 2015 and will incorporate edits/suggestions from HHSC, funders, and/or site key contacts for final submission in May 2015.
2. Two focus groups will be conducted in May and June 2015 due to delays in the implementation of these selected DSRIP projects.
3. A follow-up survey was mailed in April 2014 to patients who participated in/expressed written interest in focus group participation. Collection of quantitative data will begin summer of 2015.

XII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

In late January and early February of 2015, HHSC staff reviewed provider responses about metrics that were found to need more information to support achievement during the October DY 3 DSRIP reporting. Approvals and denials of the additional information submitted were given to

providers in early March. Those metrics that were approved will be eligible for payment in July 2015.

As previously reported, given the volume and complexity of DSRIP DY3 reporting in October 2014, HHSC staff was unable to review every metric and measure reported in October during the 30 days allowed for HHSC and CMS review, so a new approach for managing the volume of reports was implemented. CMS worked with HHSC to add language to the Program Funding and Mechanics (PFM) Protocol to specify that HHSC and CMS may determine that a subset of not less than half of the projects and metrics will be reviewed during the 30 days after the reporting period. In such instances, HHSC and CMS designated those projects and metrics that are not reviewed within 30 days as "provisionally approved." Those provisionally approved projects and metrics were reviewed in full by HHSC during January and February of 2015. After this review, HHSC requested additional information to demonstrate metric achievement for some provisionally approved metrics, and these submissions were reviewed by HHSC in March. If the initial supporting documentation, and any additional information, did not form a sufficient basis for actual metric achievement, HHSC recouped the associated overpayments from the Performing Provider. As described in waiver rules, HHSC withholds future payments until recoupment occurs.

For project metrics achieved in DY3 (including DY2 carryforward metrics), DSRIP providers received about $1.76 billion in January 2015. This included those metrics that were provisionally approved during the October reporting review. Also in Q2, the first payments for Anchor administrative costs were made.

During Q2, HHSC reviewed baseline Category 3 data submitted during the October reporting period. HHSC identified and began to follow-up with 671 projects that needed technical assistance or clarification of baseline measurement, prioritizing assistance for the projects with outcomes eligible for April DY4 reporting.

In Q2, HHSC finalized review of the nearly 2,000 RHP plan modification and technical change requests that were submitted by DSRIP providers in July and August of 2014. This included determinations by the independent assessor, Myers & Stauffer, LLP, who provided additional review of some change requests. Updated project narratives and milestones/metrics workbooks that reflect approved change requests were posted on the HHSC waiver website. With the change requests finalized, HHSC began working with RHP Anchors to draft a process for submission of updated RHP Plans.

In Q2, HHSC continued working with Myers & Stauffer on the midpoint assessment and ongoing compliance monitoring of the 677 projects selected for review. Myers & Stauffer continued with in-depth desk reviews and also conducted on-site visits with the selected providers. HHSC worked with providers to make changes to their narratives and

milestones/metrics based on Myers & Stauffer's findings. The midpoint assessment report should be completed in quarter three.

During Q2 HHSC staff completed April DY4 reporting templates, as well as an updated reporting companion document containing detailed reporting instructions and examples. Significant time during Q2 was spent resolving provider issues related to reporting their Quantifiable Patient Impact (QPI) metrics during October DY3 reporting, so that they would be able to report QPI in April for the first round of DY4 reporting.

A major initiative during Q2 was the launching of the Clinical Champions Workgroup. This workgroup is made up of clinical, quality and operational experts, who will help HHSC assess the transformational potential and impact of active DSRIP projects, identify best practices by project area, support HHSC in discussions of waiver renewal/extension and inform the clinical and quality aspects of future DSRIP protocol development. Clinical Champions nominations were solicited from Executive Waiver Committee member entities and other stakeholders. The Clinical Champions began meeting monthly in January 2015 with support from HHSC staff.

On March 9, 2015, HHSC leadership met with key CMS staff to discuss the renewal/extension of the 1115 Transformation Waiver and ways to address CMS's concerns raised in the September 2014 UC deferral letter regarding IGT financing for private hospitals. Also in March, HHSC submitted to CMS the Transition Plan for Funding Pools as required by the waiver's terms and conditions (STC 48). The Transition Plan addressed the state's experience with the DSRIP pool, actual UC trends in the state and investment in value-based purchasing and other payment reform options.

HHSC continued stakeholder communications in Q2 through biweekly Anchor calls and Executive Waiver Committee meetings. On February 12, 2014, HHSC presented on DSRIP and Uncompensated Care updates to the Executive Waiver Committee , and led a discussion on waiver renewal, including the development of the Transition Plan for Funding Pools discussed above. HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2015 Q3.

ENCLOSURES/ATTACHMENTS

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

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

Attachments C1-C3 – Network Summary and Methodology. The attachments summarize STAR and STAR+PLUS network enrollment by managed care organizations, service areas, and provider types. It also includes a description of the methodology used for provider counts and terminations.

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

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

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

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

Attachment I –MCO GeoMapping Summary. The attachment includes the STAR and STAR+PLUS plans' self-reported GeoMapping results for PCP and specialists.

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

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

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

Attachments M1-M3 – 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 and STAR+PLUS complaints and appeals received by plans.

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

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

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

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

Attachments V1-V2 –Claims Summary. The attachment is a summary of the managed care organizations' 2015 SFQ1 and SFQ2 claims adjudication results

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Date Submitted to CMS: 05/29/15

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