Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2015 State Fiscal Quarter 1, September-November

Demonstration Year (DY) 4 October-December

TABLE OF CONTENTS

I. Introduction 3
A. Managed Care Plans Participating in the Waiver Program 3
B. Monitoring Health Plans 4
C. Demonstration Funding Pools 4
II. Enrollment and Benefits Information 4
A. Eligibility and Enrollment 5
B. Enrollment Counts for the Quarter By Population 9
C. Medicaid Eligibility Changes 10
D. Anticipated Changes in Populations or Benefits 10
Delivery Networks and Access 11
A. Provider Networks 11
B. GeoAccess 12
C. Out-of Network Utilization 15
III. Outreach/Innovative Activities to Assure Access 16
A. Enrollment Broker and Plan Activities 16
B. Dental Stakeholder Meeting 17
C. Medicaid Managed Care Advisory Committee 17
D. Public Forum 17
E. Independent Consumer Supports System Plan 18
F. HHSC Managed Care Initiatives 20
IV. Collection and Verification of Encounter Data and Enrollment Data 20
V. Operational/Policy/Systems/Fiscal Developments/Issues 21
A. Update from Prior Quarter 21
B. Litigation Update 21

C. New Issues ... 23
VI. Action Plans for Addressing Any Issues Identified ... 24
VII. Financial/Budget Neutrality Development/Issues ... 24
VIII. Member Month Reporting ... 24
IX. Consumer Issues ... 25
A. Hotline Call Volume and Performance ... 25
B. Complaints and Appeals Received by Plans ... 27
C. Complaints Received by the State ... 30
X. Quality Assurance/Monitoring Activity ... 33
XI. Demonstration Evaluation ... 35
A. Overview of Evaluation ... 35
B. Summary of Evaluation Activities ... 36
C. Activties Planned in Next Quarter ... 39
XII. Regional Healthcare Partnership Participants ... 40
Enclosures/Attachments ... 43
State Contacts ... 45
Acronym list ... 46

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 14, 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; 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 SFQ1 (September-November) instead of Demonstration Year (DY) 4, Q1 ("2015 D1," covering October-December). Throughout the report, the State has identified whether the quarterly data relates to 2015 SFQ1 or 2015 D1.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2015 D1, the State contracted with 18 STAR, 5 STAR+PLUS, and 2 Dental program plans. Each health plan covers one or more of the 13 STAR service areas or 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 HEALTH PLANS

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, one created by savings generated from managed care expansion and the other from 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. A primary task of the RHPs has been to identify 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), 52, 65, 67, including quarterly and biannual trends and issues related to STAR, STAR+PLUS, and Dental Program eligibility and enrollment; enrollment counts for the quarter; Medicaid eligibility changes; anticipated changes in populations and benefits; and disenrollment from managed care. Unless otherwise provided, quarterly managed care data covers the 2015 SFQ1 reporting period (September-November) instead of 2015 D1 (October-December). Supporting data is located in Attachments B.

A. ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 65. Attachment B includes enrollment summaries for the three managed care programs.

Overall, the enrollment in Texas Medicaid managed care programs, Dental, STAR and STAR+PLUS, grew by 7.40 percent in 15SFQ1.

1. STAR

The number of members enrolled in STAR plans increased 4.65 percent from 2,781,008 in SFQ4 to 2,910,410 in SFQ1. Across the state, the largest increase in market share occurred within Blue Cross Blue Shield and Seton, for which enrollment increased by approximately 12 percent each in SFQ1. A possible explanation for this increase is that members may not have lost eligibility or not transferred MCOs during the quarter. The only MCO to lose members in SFQ1 was Scott & White health plan; enrollment decreased by 3.39 percent from SFQ4.

By service delivery area (SDA), the largest enrollment gains occurred in Tarrant SDA, in which Aetna, Cook, and Amerigroup increased by approximately seven percent each. In the Medicaid Rural Service Areas (MRSA), enrollment likely decreased due to the expansion of STAR+PLUS effective September 1, 2014. In the Central, Northeast, and West MRSAs, enrollment decreased by 4.5, 7.2, and 3.5 percent, respectively in SFQ1. This could be due to certain child and SSI adult populations in the MRSA who were previously in STAR but with the STAR+PLUS expansion had the opportunity to choose either managed care (STAR+PLUS) or fee-for-service delivery model.

Market Share by STAR MCO (2014-2015)

STAR	2014 Q2	2014 Q3	2014 Q4	2015 Q1
Aetna	2.32%	2.40%	2.47%	**2.53%**
Amerigroup	20.09%	19.84%	19.79%	**19.64%**
BCBS	0.61%	0.67%	0.73%	**0.78%**
CHC	7.92%	7.91%	7.88%	**8.00%**
Christus	0.29%	0.27%	0.25%	**0.25%**
Community 1st	3.47%	3.58%	3.65%	**3.76%**
Cook Children's	3.07%	3.20%	3.31%	**3.42%**
Driscoll	4.13%	4.22%	4.29%	**4.44%**
El Paso 1st	2.09%	2.15%	2.17%	**2.21%**
FirstCare	3.43%	3.42%	3.37%	**3.21%**
Molina	3.69%	3.73%	3.58%	**3.56%**
Parkland	6.37%	6.37%	6.33%	**6.40%**
Scott & White	1.37%	1.43%	1.49%	**1.38%**
Sendero	0.37%	0.38%	0.41%	**0.42%**
Seton	0.46%	0.49%	0.53%	**0.57%**
Superior	25.87%	25.25%	24.75%	**23.96%**
Texas Children's	10.48%	10.69%	11.01%	**11.44%**
United	3.98%	3.99%	3.99%	**4.05%**

2. STAR+PLUS

The number of members enrolled in STAR+PLUS plans increased by 25.73 percent from 412,110 in SFQ4 to 518,152 in SFQ1, due to the expansion of STAR+PLUS in the MRSAs. In the non MRSA SDAs, all STAR+PLUS MCOs gained members in SFQ1.

Unlike SFY 2014, overall market share by MCO changed, shown in the graph below. Amerigroup and Molina lost members in the STAR+PLUS program while Cigna-HealthSpring and United gained. Superior enrollment remained steady.

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

STAR+PLUS	2014 Q2	2014 Q3	2014 Q4	2015 Q1
Amerigroup	28.97%	28.82%	28.77%	**26.59%**
Cigna-HealthSpring	6.06%	6.10%	6.09%	**8.89%**
Molina	22.03%	22.02%	22.09%	**17.79%**
Superior	27.23%	27.07%	26.87%	**27.49%**
United	15.71%	15.98%	16.17%	**19.25%**

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

Figure 1: STAR Program Enrollment by MCO and Service Area (2014-2015)

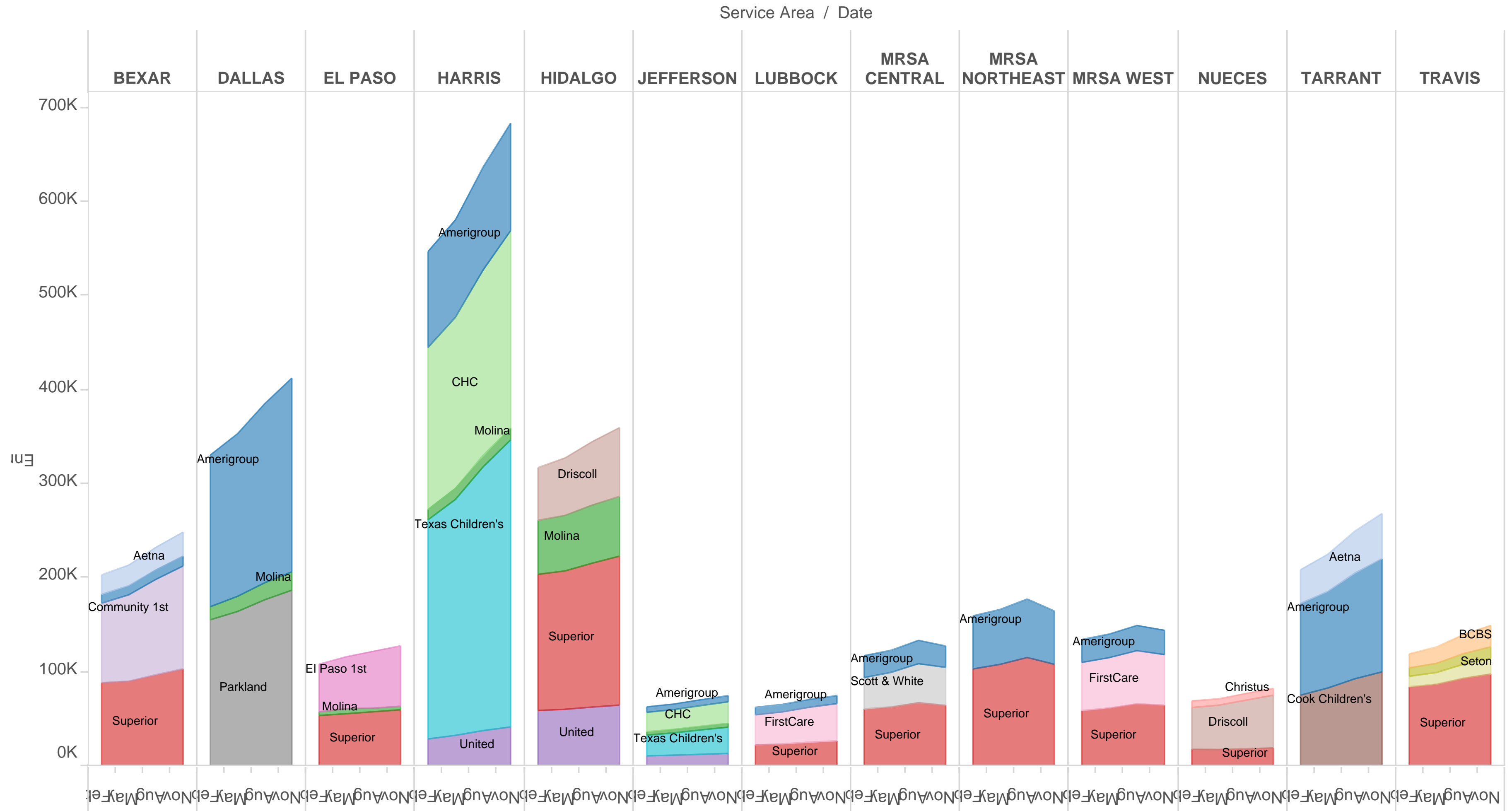


Figure 2: STAR+PLUS Non-MRSA Program Enrollment by MCO and Service Area (2014)

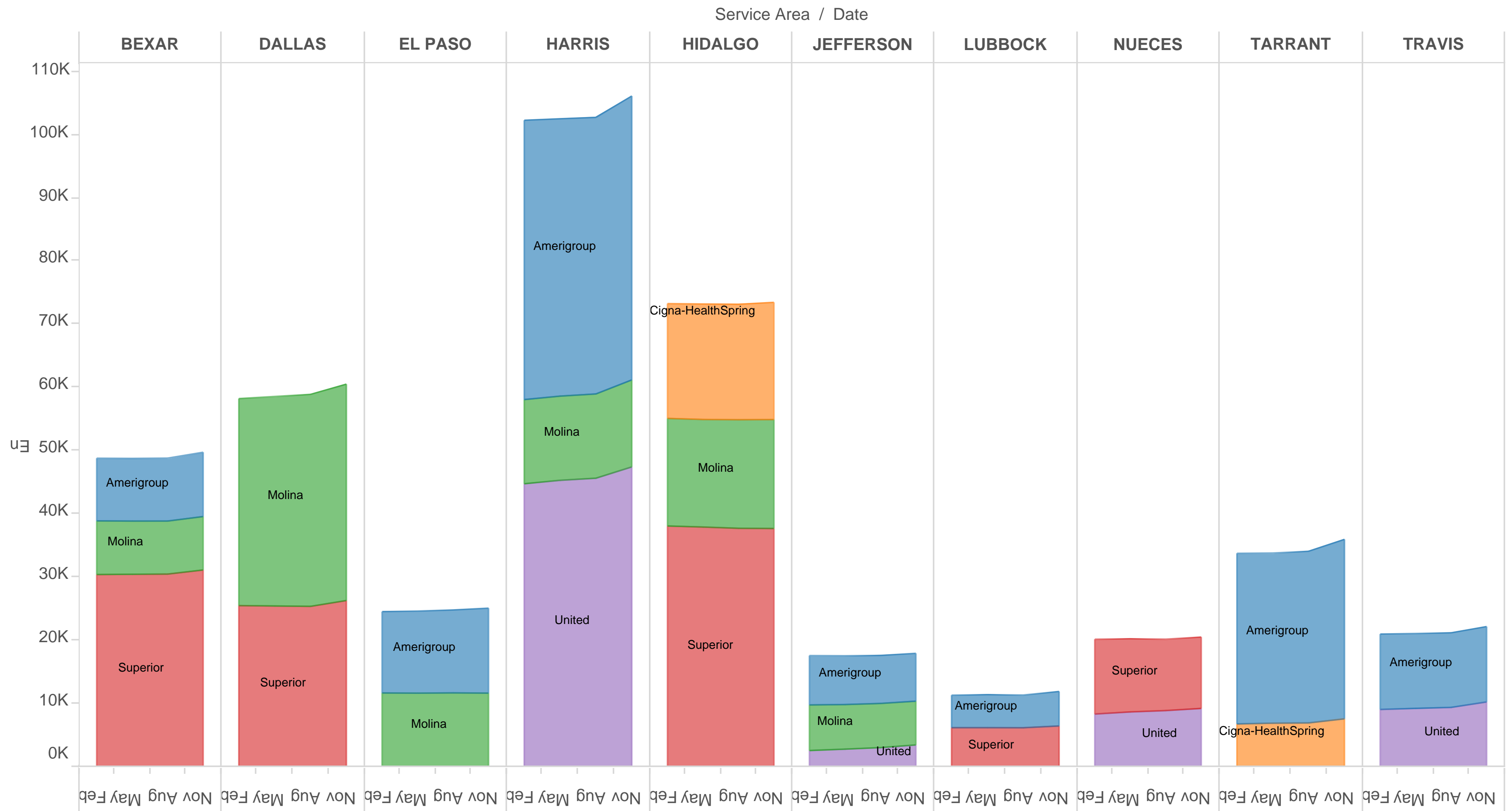
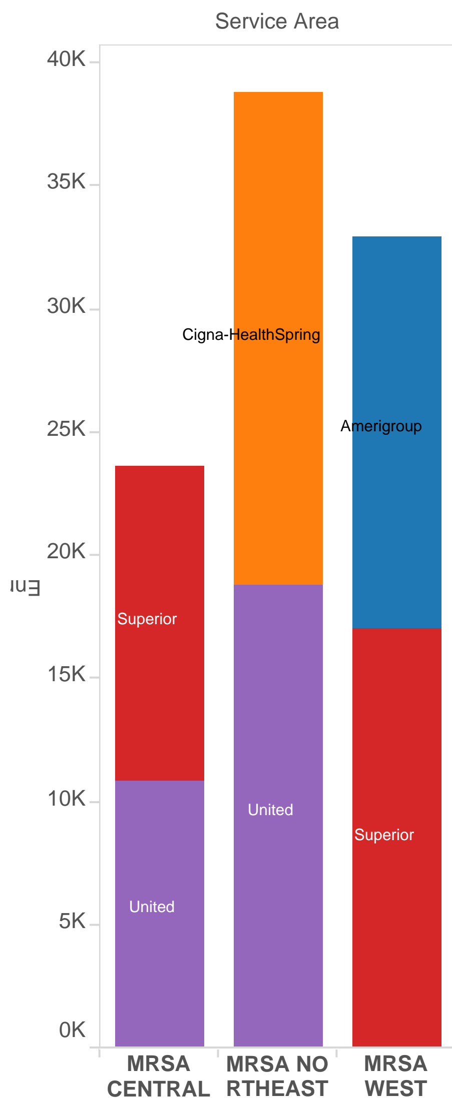


Figure 3: STAR+PLUS MRSA Program Enrollment by MCO and Service Area (2014)



Total enrollment in the Dental program increased by 6.27 percent to 2,914,867 members in SFQ1. Both DentaQuest and MCNA enrollments increased by approximately six percent each between SFQ4 and SFQ1. 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 section includes quarterly enrollment counts, as required by STC 65. Due to the time required for the data collection process, unique client counts per quarter are reported on a two quarter lag. The following table includes enrollment counts for the 2014 Federal Fiscal Quarter 3. Enrollment counts are based on persons, and not member months.

Enrollment Counts for (2014)

Demonstration Populations	Total Number
Adults	330,626
Children	2,634,956
Aged and Medicare Related (AMR)	310,696
Disabled	442,228

C. MEDICAID ELIGIBILITY CHANGES

With the exception of the conversion to a modified adjusted gross income (MAGI) standard effective January 1, 2014, no additional eligibility changes were made to the 1115 waiver populations.

D. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

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

Also effective March 1, 2015, under the Dual Demonstration, HHSC will test an innovative delivery model that combines health services for people with both Medicaid and Medicare coverage into one plan. The demonstration will include full-dual eligible adults (age 21 and above) who reside in a STAR+PLUS service area that currently receive their Medicaid benefits through the STAR+PLUS managed care program. One entity will be responsible for coordinating the full array of Medicaid and Medicare services. The demonstration will be implemented in the following six counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant.

Dependent upon Centers for Medicare & Medicaid Services (CMS) approval, 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.

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

Medicaid Average Monthly Caseload Forecasts (2014-2017)

Current World	FY 2014	FY 2015	FY 2016	FY 2017
Total FFS	735,000	733,000	751,000	771,000
Total Managed Care	3,012,000	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%*

DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly reporting requirements found in 39(a) and 65. Supporting data is located in Attachments C through H. 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 members have access to at least two age appropriate PCPs within established mileage standards.

Across the STAR program statewide, the health plans reported a total of 16,147 unique PCP providers. The health plans reported 12,597 unique PCP providers in the STAR+PLUS program statewide. Across both STAR and STAR+PLUS health plans networks included 17,390 unique PCP providers. The Harris and Jefferson SDAs have the highest number of PCP providers in both STAR and STAR+PLUS.

2. Specialists (non-pharmacy)

Across the STAR program statewide, the health plans reported a total of 51,238 unique specialty providers. The health plans reported 43,379 unique specialty providers in the STAR+PLUS program statewide. Across both STAR and STAR+PLUS health plans networks included 53,990 unique specialty providers. The Harris and Jefferson SDAs have the highest number of specialty providers in both STAR and STAR+PLUS.

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in 2015 SFQ1. 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.

3. Pharmacy Providers

Across the STAR program statewide, the health plans reported a total of 4,792 unique pharmacies. The health plans reported 4,697 unique pharmacies in the STAR+PLUS program statewide. Across both STAR and STAR+PLUS, health plan networks included 4,798 unique pharmacies. The Dallas, Harris, Jefferson, and Tarrant SDAs have the highest number of pharmacies, which is expected based on the enrollment for those areas. Scott& White STAR in MRSA Central and Blue Cross Blue Shield STAR in Travis SDA reported over four thousand pharmacies in their statewide network. Of those, approximately two hundred pharmacies are within the MRSA Central and four hundred in Travis SDA. The MCOs contract with the other pharmacies to ensure members have access if traveling outside the SDA. HHSC will follow up with the other MCOs to determine if pharmacy counts include providers from outside the SDA and issue guidance in order to make reporting consistent.

4. Dental Program Provider Counts

In 2015 SFQ1, DentaQuest reported a total of 4,927 unique dental providers. MCNA reported 4,056 unique dental providers. Across the dental program statewide, there were 5,166 unique dental providers in the state.

B. GEOACCESS

The data below is based on HHSC Strategic Decision Support (SDS) geomapping reports from 2015 SFQ1. Attachments E, G, and H show HHSC geomapping results by plan and SDA for the following provider types and populations:

- All STAR and STAR+PLUS members: open panel PCP; pharmacy
- Children STAR and STAR+PLUS: otolaryngologist (ENT)

- Dental members: main dentists; endodontic; oral surgery; orthodontic; periodontist; prosthodontist

If the MCO does not meet the mileage or out-of-network standards, it may submit a 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.

1. Access to PCPs and ENTs

Attachment E shows the geoaccess measures by MCO for PCPs and ENTs. For all STAR and STAR+PLUS service areas, the following benchmarks applied:

- 90 percent – access to at least one open panel PCP for adults and two open panel PCP for children
- 90 percent – access to ENT for children

The 15SFQ1 results demonstrate that across the state, the STAR and STAR+PLUS programs exceeded the State's 90 percent benchmarks for most provider types. 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.

2. 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 MRSAs)
- 75 percent – access to a network pharmacy in suburban counties within 5 miles (55 percent in 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 SFQ1. The greatest shortfalls are pharmacies in the MRSAs, especially MRSA Northeast. While HHSC received eighteen member complaint regarding pharmacies in MRSA West and MRSA Northeast, none of the complaints were related to access to pharmacies. 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 Navitus, the Pharmacy Benefits Manager (PBM) for many of the MCOs, Medicaid members may access any network pharmacy within or outside of the distance criteria. Also, if the pharmacy is enrolled with Texas Medicaid Vendor Drug Program, and not Navitus, an out-of-network override is available in order to process claims for the non-contracted pharmacy. HHSC is in the process of researching the Navitus policy with the other PBMs.

3. Dental GeoMapping

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

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

- 100 percent – 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 SFQ1, 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 (DMOs) report continuing activities to monitor the State Licensing Board website, HHSC claims administrator website, and utilize other internet resources in an effort to identify potential recruitment opportunities. HHSC received and approved a special exception from DentaQuest for 2015 SFQ1 and SFQ2. MCNA was not in compliance for access to dental specialists in all SDAs nor did the DMO submit a special exception. Therefore, HHSC is in the process of developing an appropriate remedy for MCNA.

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 SFQ1 of 2015:

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

Within the STAR and STAR+PLUS programs in 2015 SFQ1, 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.

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

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

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. Plans that do not exceed OON utilization thresholds 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 65 regarding outreach and other initiatives to ensure access to care. The Dental Stakeholder Update addresses STC 40(c), the Medicaid Managed Care Advisory Committee meeting update also addresses STC 65.

A. ENROLLMENT BROKER AND PLAN ACTIVITIES

The state's Enrollment Broker, MAXIMUS, performs various outreach efforts to educate potential clients about their medical and dental enrollment options. During the 2015 D1 Demonstration period (October-December 2014), MAXIMUS sent 337,711 enrollment mailings to potential STAR and STAR+PLUS clients, and 223,114 mailings to potential dental program clients. MAXIMUS field staff completed 24,381 home visit attempts for these programs, and 87,564 phone call attempts. Additionally, MAXIMUS completed 5,929 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 continue to answer questions submitted to the State's dental stakeholder email box: DentalStakeholderMeeting@hhsc.state.tx.us. HHSC also participated in a meeting with the Texas Dental Association on September 5, 2014, to discuss provider concerns and issues.

C. MEDICAID MANAGED CARE ADVISORY COMMITTEE

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

The SMMC held one meeting in SFQ1 on October 23, 2014. At that meeting, the committee adopted 26 managed care recommendations. The recommendations are described within a report that is currently under agency review.

D. PUBLIC FORUM

In accordance with STC 14, Post Award Forum, HHSC afforded the public with an opportunity to provide comment on the progress of the Demonstration at the quarterly HHSC Stakeholder Forum, held on October 13, 2014. The date, time and location of the Stakeholder Forum were published on the HHSC website at least 30 days prior to the date of the forum. The HHSC Stakeholder Forum is open to the public. HHSC staff presented an overview of progress to date on the demonstration waiver and took questions and feedback from those in attendance. An archived recording of the forum is posted on the HHSC website.

E. INDEPENDENT CONSUMER SUPPORTS SYSTEM PLAN

HHSC submitted a plan to CMS on May 1, 2014, describing the structure and operation of the Independent Consumer Supports System (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

The Medicaid Managed Care Helpline (MMCH) team currently includes 8 Advocates, a Team Lead, and a Manager. The team averaged a call abandonment rate of less than 10 percent in the last month. Call volume increased in August and September 2014 due to the managed care expansions in September, but has since returned to normal levels. For example, for the week ending December 19, 2014, MMCH received 671 calls with an Abandonment Rate of 4 percent (only three percent holding more than 30 seconds). By March 1, 2015, MMCH will add 7 additional positions to perform the following functions and improve consumer support around the state:

- Two advocate positions to resolve consumer issues resulting from the September 2014 and March 2015 expansions.
- One program specialist to be responsible for long-term planning for Medicaid managed care programs.
- Two positions that would resolve escalated, complex consumer issues.
- Two positions to focus on increased integration and coordination with ICSS component organizations and with Health and Human Services staff located around the state.

2. Long Term Care Ombudsman

The Office of the State Long-term Care Ombudsman is an office housed within the Department of Aging and Disability Services (DADS), and is independent of DADS and MCOs. Seven state office staff support and oversee statewide long-term care ombudsman (LTCO) operations, which are provided directly by an area agency on aging (AAA), or by contract with a local non-profit organization. In these local agencies, over 600 volunteers and the equivalent of 68 full-time staff are certified ombudsmen. Most nursing homes are visited monthly, and when a complaint is received, an LTCO must take action within two business days. Complaints are predominately identified while an LTCO is onsite at a facility, but may also be received by phone, in writing by

email, or an office visit. Resolution can occur in a matter of days, or may take weeks or months depending on the complexity of the problem.

An LTCO advocates for quality of life and care for nursing home and assisted living facility residents and helps protect their health, safety, welfare, and rights. In nursing homes, an LTCO supports managed care consumers by identifying, investigating, and working to resolve complaints about managed care services and supports. This may include problems with enrollment, service coordination, and appeals. With resident permission, an LTCO may represent a resident's interests with the MCO or HHSC in an appeal. Some long-term care ombudsmen are bilingual Spanish and English speakers. In portions of Texas, bilingual skills are necessary to meet the demand for services on a daily basis. Where Spanish-speaking residents are less populous in nursing homes, Spanish-language interpretation may be provided by a resident's family member, trusted staff identified by the resident, or using an approved language translation telephone line.

Training on the role of managed care, enrollment, and membership rights was initially provided to certified ombudsmen in fall 2014. Training and reference materials were shared to support an LTCO's work with residents during the initial enrollment phase; in 2015, materials will be updated and incorporated into basic training for certification as an LTCO.

Ombudsman complaint data is collected in a secure, web-based database that is separate from the HHSC Ombudsman and DADS Regulatory Services systems. Ombudsman data is collected on a monthly basis and evaluated by the office of the LTCO quarterly, annually, and as needed for program monitoring purposes. One of the purposes of collecting data is to determine trends and make recommendations for changes in policy, rule, and law. Additional ombudsman complaint codes were created so an LTCO can report problems that are specific to managed care. These will be monitored by the state office for trends.

To resolve some problems, the LTCO program coordinates with other programs and agencies, such as DADS Regulatory Services, legal aid, MCOs, and the HHSC Ombudsman. Professionals within an AAA or ADRC are also helpful resources to the LTCO resolution process. Coordination with DADS regional Regulatory Services offices, legal aid, MCOs, AAAs, and ADRCs usually occurs at the local level. Coordination with the HHSC Ombudsman, other parts of HHSC, the EB, corporate level contacts with MCOs and nursing homes, and some legal questions occurs with involvement from the state office. The state office also coordinates complaints that require escalation and intervention from state agencies. As an example, during the initial enrollment phase of the nursing home carve-in to the 1115 waiver, ombudsmen were trained by the EB on the presentation content provided to nursing home residents. When possible, an LTCO attends presentations in nursing homes made by the EB and offers support and encouragement of residents' rights and facility requirements related to enrollment. When

problems are identified regarding a resident's choice of MCO, the ombudsman investigates and coordinates with the EB and HHSC to educate and remove any barriers to choice of health plan.

3. Aging and Disability Resource Center

In September 2014, DADS completed the ADRC expansion as required by the Balancing Incentive Program (BIP). Twenty-two ADRCs now provide services statewide in all 254 counties in Texas. The ADRCs are also implementing significant structural changes to ensure consistent service delivery and enhanced consumer access statewide. A toll-free number for access to the statewide ADRC network was launched in January 2015. Callers are routed to the ADRC in their area via their zip code. ADRCs will implement a person-centered long term service and support screening tool in August 2015. This screening tool will be accessible on-line, by phone or in person at an ADRC to assess an individual's long term service and support needs and electronically generate referrals to the public benefits which may meet those needs. ADRCs will play a key role in addressing referral management issues and system navigation issues, working in close coordination with the key consumer support teams within the Office of the Ombudsman and the Enrollment Broker.

F. HHSC MANAGED CARE INITIATIVES

Nursing facility residents that will be newly eligible for STAR+PLUS starting March 1, 2015 began receiving enrollment packets at the end of November 2014. The enrollment period ends in February 2015 and any mandatory candidate who had not selected a health plan will be defaulted into a plan by HHSC. Choice and default enrollment rates will be reported in the subsequent quarterly report. The Enrollment Broker holds enrollment events in nursing facilities across the state November 2014 – February 2015.

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

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

IV. COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

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

The state continues to conduct the quarterly MCO encounter financial reconciliation process for 2015 SFQ1. The state will contact each plan that did not achieve the financial reconciliation threshold, and advise them of the necessary steps to achieve contract compliance and, ultimately, certification.

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

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

A. UPDATE FROM PRIOR QUARTER

HHSC 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 <u>must</u> 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. 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 has recently been 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 HHSCs 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, but remains pending. Of all the lawsuits filed in 2011-2012 challenging HHSC's expansion of the Medicaid managed care delivery model, *Kawaja* is the sole case still pending. All others have been dismissed or resolved.

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 sections. In 2007, the parties agreed to 11 corrective action orders to bring the state into compliance with the consent decree and increase access to THSteps' services. The corrective action orders touch upon many program areas, and generally require the state to take actions intended to assure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in all 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 the state defendants had complied with the required actions. Most recently, on January 20, 2015, in *Frew v. Janek*, the U.S. District Court found that HHSC has shown to have satisfied the objectives the correction action order related to Adequate Supply of Providers and paragraph 88 of the consent decree relating to adequate supply of providers. The court found that the state achieved this by taking realistic and viable measures to enhance recipients' access to care through ensuring an adequate supply of health care providers, both primary care and specialists, by using targeted recruitment efforts, increasing and monitoring 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.

VI. ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

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

1. Managed Care Issues

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

2. Litigation

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

3. Other

There were no fiscal or systems issues, or legislative activity that occurred in 2015 SFQ1.

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 SFQ1.

VIII. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements in STC regarding eligible member month participants, in compliance with STC 52.

Eligibility Groups Used in Budget Neutrality Calculations (2014 Q4)

Eligibility Group	Month 1 (Oct 2014)	Month 2 (Nov 2014)	Month 3 (Dec 2014)	Total for Quarter Ending Dec 2014
Adults	293,059	292,124	290,726	875,908
Children	2,688,083	2,692,950	2,696,945	8,077,978
AMR	361,507	362,327	359,202	1,083,035
Disabled	452,878	427,463	426,860	1,280,201

Figure 26: Eligibility Groups Not Used in Budget Neutrality Calculations (2014 Q4)

Eligibility Group	Month 1 (Oct 2014)	Month 2 (Nov 2014)	Month 3 (Dec 2014)	Total for Quarter Ending Dec 2014
Adults in MRSA	-	-	-	-
Foster Care	34,013	33,950	34,104	102,067
Medically Needy	156	151	151	458
CHIP-Funded	209,154	232,858	256,833	698,845
Adoption Subsidy	43,477	43,693	43,909	131,079
STAR+PLUS 217-Like HCBS	161,749	16,762	16,679	50,190

IX. CONSUMER ISSUES

This section addresses quarterly reporting requirements in STC 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 8 percent in 2015 SFQ1. Calls to the MCO provider hotlines decreased by two 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 15 and 12 percent, respectively, in SFQ1.

The following graph shows the number of calls received to the member hotline per 1000 members in quarters 2 through 4 of 2014 and quarter 1 of 2015.

Member Hotline Calls Received per 1000 Members (2014 Q2 - 2015 Q1)

MCO	Member Hotline per 1000 Members			
	14 Q2	14 Q3	14 Q4	15 Q1
Aetna*	623	590	541	**541**
Amerigroup*	212	209	213	**208**
BCBS*	364	366	330	**305**
CHC*	217	222	225	**201**
Christus*	353	348	324	**317**
Cigna-HealthSpring	761	920	1,025	**911**
Community 1st*	158	136	129	**123**
Cook Children's*	332	275	222	**226**
DentaQuest	82	89	77	**76**
Driscoll*	162	162	166	**169**
El Paso 1st*	419	233	206	**197**
FirstCare*	201	185	174	**149**
MCNA	107	118	102	**102**
Molina*	423	404	385	**386**
Parkland*	301	276	242	**246**
Scott & White	347	322	379	**346**
Sendero*	389	279	320	**226**
Seton*	509	430	777	**648**
Superior*	279	261	250	**251**
Texas Children's*	131	130	111	**100**
United*	439	438	439	**500**
Statewide (excludes dental program)	**87**	**85**	**85**	**88**
*Enrollment and Hotline data includes CHIP program				

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

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

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 decreased from 2014 SFQ4 to 2015 SFQ1, as shown in the figures below. STAR plans collectively reported 729 member complaints, 1,614 member appeals, and 253 provider complaints in SFQ1. STAR+PLUS plans resolved 1,177 member complaints, 1,013 member appeals, and 169 provider complaints in SFQ1. Amerigroup, Superior, United, and Molina make up more than 60 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.

Aetna received an increase in miscellaneous member complaints over the past four quarters. The plan reported that the increase is due to issues related to providers balance billing members. Most of the complaints had to do with out-of-network providers. Aetna staff educate all providers, participating and non-participating, on policies related to billing Medicaid members. In addition, Aetna staff advises members, when they are not responsible, to submit copies of correspondence from the provider, and the plan follows up with the provider directly.

Figure 16: Complaints and Appeals Received by STAR MCOs (2014 Q2 – 2015 Q1)

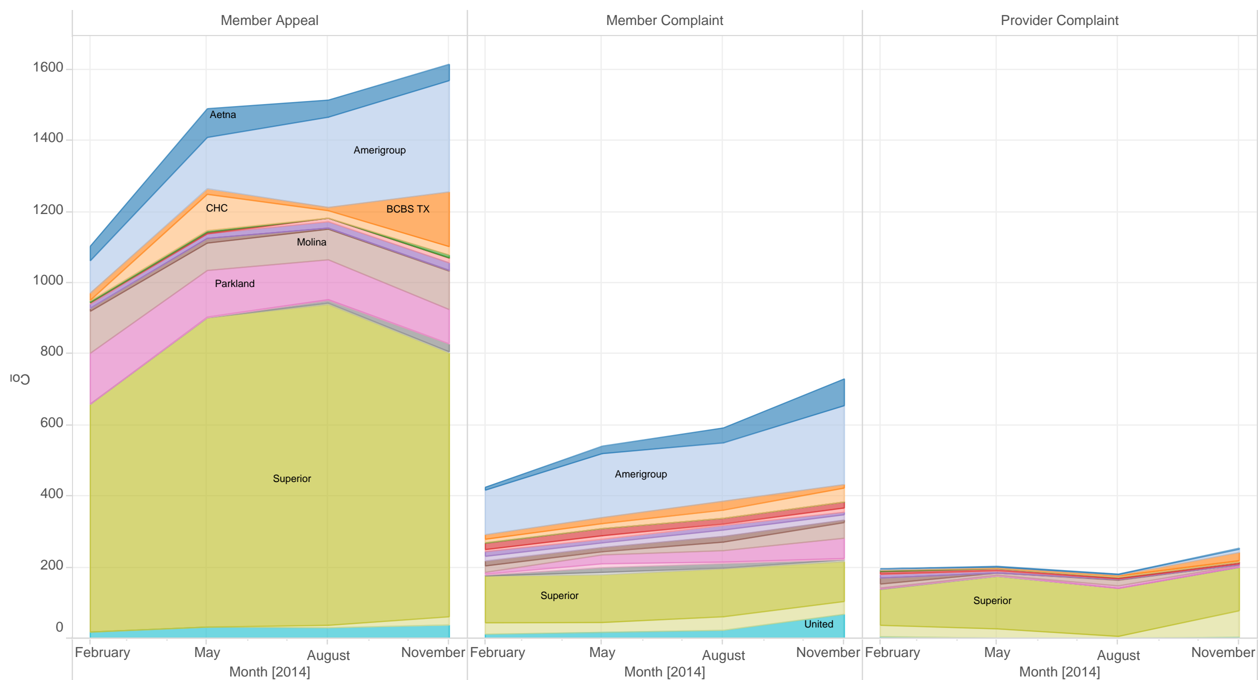
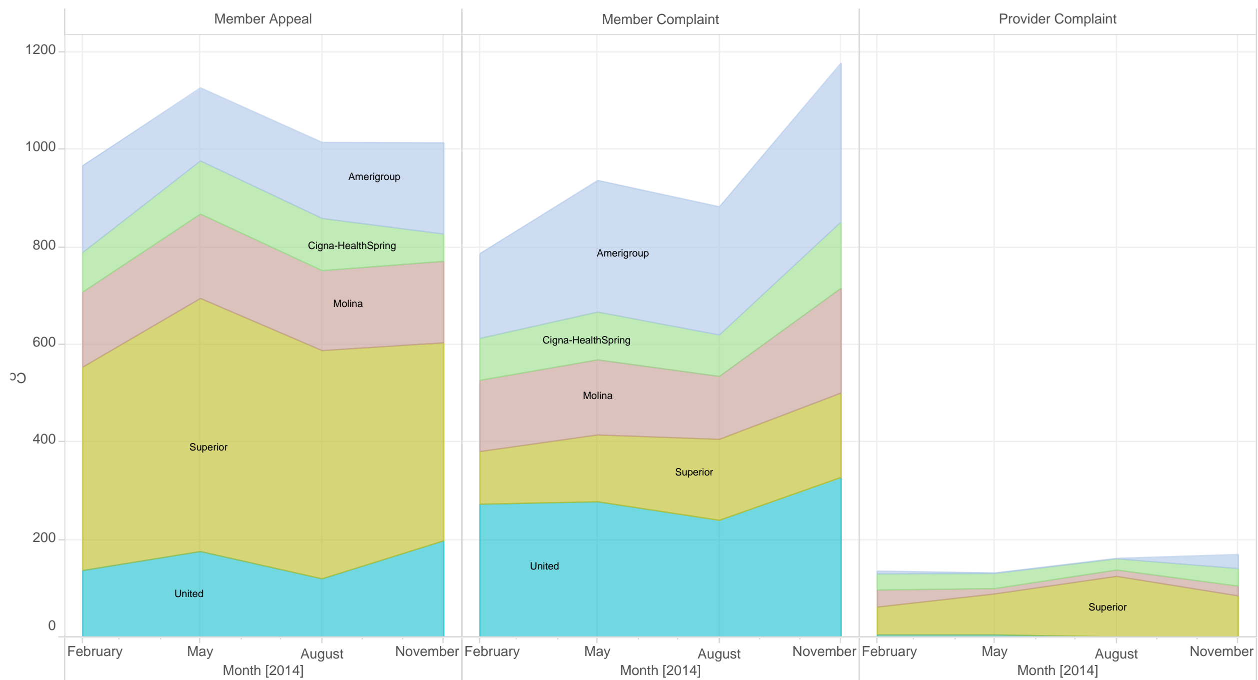


Figure 17: Complaints and Appeals Received by STAR+PLUS MCOs (2014 Q2 – 2015 Q1)



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 SFQ1. HHSC staff is in the process of developing appropriate remedies for the following MCOs.

- Amerigroup STAR in Lubbock SDA failed to meet the standard for member appeals.
- United STAR in Harris SDA failed to meet the standards for member complaints and appeals.
- United STAR in Hidalgo SDA failed to meet the standard for member appeals.
- Amerigroup STAR+PLUS in El Paso SDA failed to meet the standard for member appeals.
- Cigna-HealthSpring STAR+PLUS in Hidalgo failed to meet the standard for member appeals.
- United STAR+PLUS in Harris, MRSA Central, MRSA Northeast, Nueces, and Travis SDAs failed to meet the standard for member appeals.

2. Dental Program

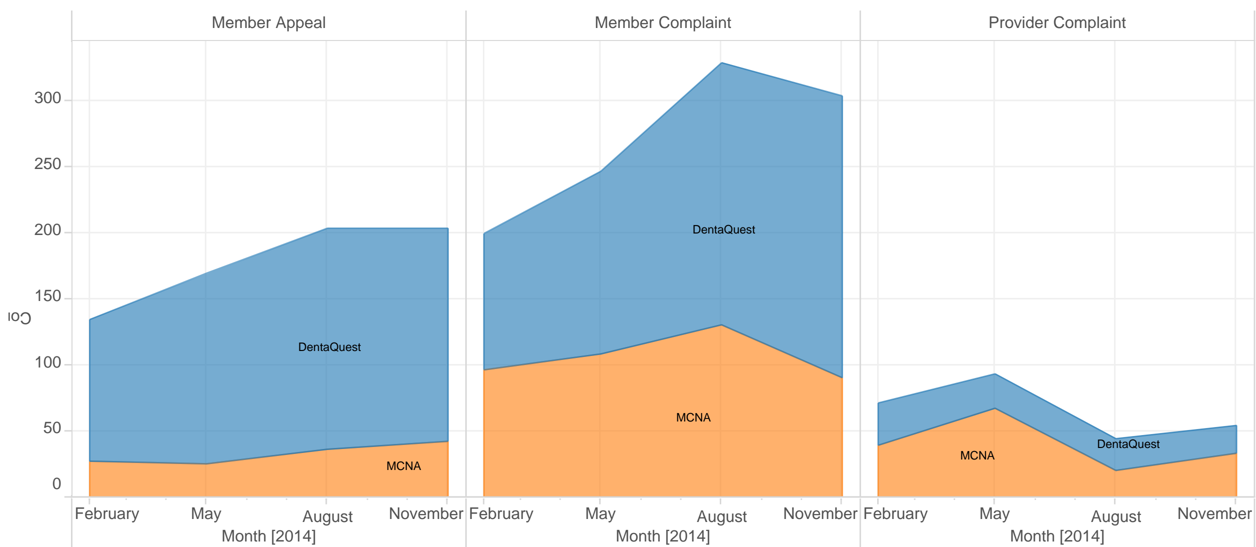
Between 14SFQ4 and 15SFQ1, dental member complaints increased by 6 percent, member appeals stayed the same, and provider complaints increased by 22 percent. The most common member complaint to the dental plans involved either dissatisfaction with the quality of care provided by a treating dental provider, 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, so any fluctuations within service areas is not captured by HHSC. Each health plan has over one million members enrolled across the state, therefore, the changes in complaints and appeals represent a very small fluctuation as a percentage of enrolled members that may be expected between fiscal quarters as utilization patterns change.

	Member Complaints per 1000 Members				Member Appeals per 1000 Members			
	14 Q2	**14 Q3**	**14 Q4**	**15 Q1**	**14 Q2**	**14 Q3**	**14 Q4**	**15 Q1**
DentaQuest	0.08	0.10	0.13	0.13	0.08	0.10	0.11	0.10
MCNA	0.09	0.10	0.11	0.07	0.03	0.02	0.03	0.03
Dental Program	**0.08**	**0.10**	**0.12**	**0.12**	**0.06**	**0.07**	**0.07**	**0.07**

MCNA and DentaQuest met all performance standards for the timely resolution of complaints and appeals in SFQ1.

Figure 18: Complaints and Appeals Received by DMOs (2014 Q2 – 2015 Q1)



C. COMPLAINTS RECEIVED BY THE STATE

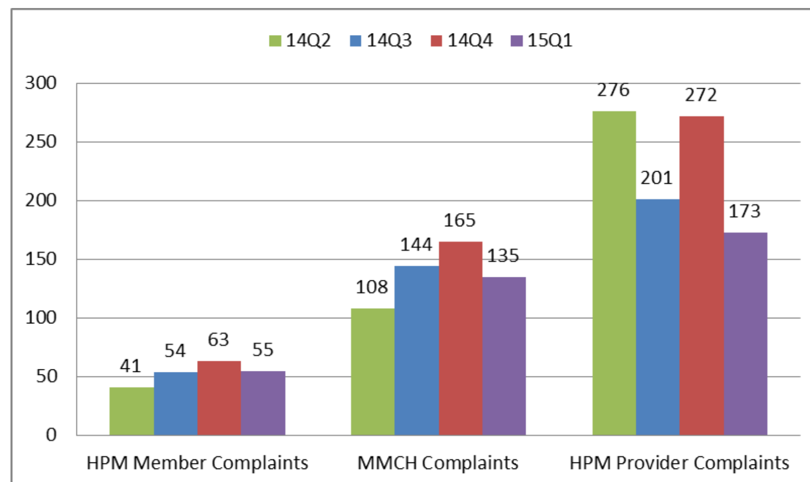
In addition to monitoring complaints received by plans, HHSC also tracks the number and types of complaints submitted to the state. Members and providers can submit complaints to the HHSC HPM team. Members can also call in to submit complaints through the Ombudsman's office via the MMCH. After investigating 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).

The data discussed below includes complaints regarding the managed care expansions that occurred on September 1, 2014.

1. STAR

In the STAR program, the number of member complaints received by HPM and MMCH overall decreased by 17 percent. The most common member complaint issues 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 decreased by 36 percent in 2015 SFQ1. The most common issue type of provider complaints received by HPM was denial of claim.

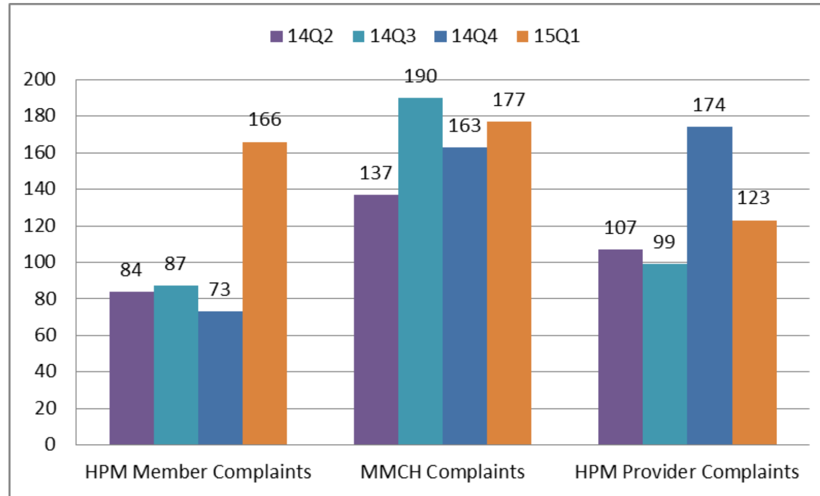
Figure 19: Complaints to the State Regarding STAR (2014 Q2- 2015 Q1)



2. STAR+PLUS

Across the STAR+PLUS program, the number of member complaints received by MMCH and HPM increased by 45 percent, likely due to the September 1, 2014 expansion to the MRSAs. 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 decreased by 29 percent in 2015 SFQ1.

Figure 20: Complaints to the State Regarding STAR+PLUS (2014 Q2- 2015 Q1)



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 166 member complaints received by HPM, 35 came from members in the MRSAs. Of the 123 provider complaints received in STAR+PLUS, 15 had to do with the MRSAs. The most common provider complaint issue had to do with denied claims.

Complaints to the State Regarding 9/1/2015 STAR+PLUS Expansion (2015 Q1)

MCO	Member Complaints	Provider Complaints
Amerigroup	5	3
Cigna-HealthSpring	13	1
Superior	8	5
United	9	6
Total	**35**	**15**

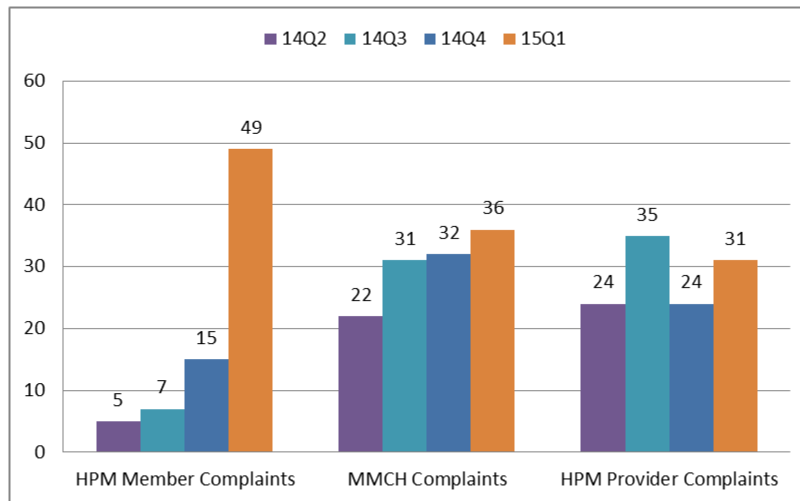
Complaints to the State Regarding STAR, STAR+PLUS, and 9/1/2015 STAR+PLUS Expansion (2015 Q1)

STAR	Member Complaints per 1000 Members
Aetna	**0.04**
Amerigroup	**0.05**
BCBS	**0.13**
CHC	**0.06**
Christus	**0.00**
Community 1st	**0.04**
Cook Children's	**0.21**
Driscoll	**0.04**
El Paso 1st	**0.05**
FirstCare	**0.07**
Molina	**0.16**
Parkland	**0.02**
Scott & White	**0.10**
Sendero	**0.41**
Seton	**0.30**
Superior	**0.06**
Texas Children's	**0.03**
United	**0.09**
STAR+PLUS	
Amerigroup	**0.47**
Cigna-HealthSpring	**1.15**
Molina	**0.80**
Superior	**0.84**
United	**0.74**
STAR+PLUS MRSA	
Amerigroup	**0.31**
Cigna-HealthSpring	**0.65**
Superior	**0.27**
United	**0.30**

3. Dental Program

Across the dental program, the number of member complaints received by MMCH and HPM increased by 80 percent in 2015 SFQ1. HPM received an increase in the total number of dental member complaints for both DMOs, but MCNA had the most dramatic increase. The most common member complaint issue types about the dental program had to do with incorrect eligibility or enrollment information and access to care. The most common provider complaint issue type received had to do with denied claims. Provider complaints increased 29 percent from 2014 SFQ4 to 2015 SFQ1.

Figure 22: Complaints to the State Regarding the Dental Program (2014 Q2- 2015 Q1)



X. QUALITY ASSURANCE/MONITORING ACTIVITY

As directed by Senate Bill 7, 82nd Legislature, First Called Session, 2011, HHSC continues to release MCO report cards to help members of STAR, STAR+PLUS, and CHIP identify and select a health plan. During SFQ1, 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 and will be included in the enrollment packets sent to all newly eligible members. The measures will continue to be reviewed and updated annually.

HHSC is revising its performance improvement project (PIP) process in an effort to improve the quality of MCO PIPs. Recent changes extend all 2014 PIPs until at least 2015 and make future PIPs two-year projects. In SFQ1, HHSC concluded the individualized technical assistance calls for all MCOs that scored five percent or more below average on at least one of their 2014 PIP plans.

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

During Q1, HHSC engaged in conversations with NASUAD and HSRI regarding project planning.

During SFQ1, HHSC began 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. Enhancements to the program include:

- Each dental plan is at-risk for four percent of their capitation during calendar year 2015.
- Plans have the opportunity to earn back their at-risk amount plus additional dollars based on the level of performance improvement.

During SFQ1, HHSC's EQRO reported on MCO performance on quality measures. The 2013 Quality of Care data was used to:

- Calculate the results of the 2013 the At-Risk/Quality Challenge
- Provide baseline data for 2014 P4Q
- Determine star ratings by plan and services area for MCO reports cards
- Assist the health plans in monitoring their individual performance

During SFQ1, Texas's EQRO released three reports. These reports were posted to the HHSC website and made available to the public.

- "The Texas STAR+PLUS Program Member Survey Report" which includes the results of a STAR+PLUS member survey assessing health care experiences and satisfaction. The STAR+PLUS member survey was conducted for Medicaid-only members who were enrolled in one of the five STAR+PLUS MCOs between July 2011 and December 2011. This report can be found at http://www.hhsc.state.tx.us/reports/2014/eqro-FY2012.pdf
- "Potentially Preventable Readmissions in Texas Medicaid and CHIP Programs" which provides information on the occurrence of potentially preventable hospital readmissions for enrollees of Texas Medicaid and CHIP programs during fiscal year 2013. This report can be found at http://www.hhsc.state.tx.us/reports/2014/PPR-Statewide-Report-FY2013.pdf
- "Potentially Preventable Complications in Texas Medicaid and CHIP Programs" which provides information on the occurrence of potentially preventable hospital complications for enrollees of Texas Medicaid and CHIP programs during fiscal year 2013. This report can be found at http://www.hhsc.state.tx.us/reports/2014/PPC-Statewide-Report-FY2013.pdf

XI. DEMONSTRATION EVALUATION

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

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from October 1, 2014 through December 31, 2014.

The Program includes two interventions:

> Intervention I: The expansion of the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, and 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 short-term (process measures) and intermediate (health outcomes) performance measures of the Program. The performance measures will be used to assess the extent to which the Program accomplishes its goals, tracks changes from year to year, and identifies opportunities for improvement.

This report identifies:

- the current quarter's evaluation activities
- any challenges or issues encountered
- 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 Texas A&M team members attended the 142nd Annual meeting and exposition of the American Public Health Association (APHA) conference (November 15 to 19, 2014). Team members facilitated two oral presentations, one poster session, and one round table:
    a. Using quality measures to monitor and evaluate the impact of pharmacy carve-in implemented through an 1115(a) demonstration waiver: The Texas healthcare transformation and quality improvement program
    b. Texas Healthcare Transformation and Quality Improvement Program: Impacts of Medicaid policy change on quality of care for aged and disabled population
    c. A pragmatic approach to guide the design of a mixed methods evaluation of a Medicaid 1115(a) waiver: The Texas healthcare transformation and quality improvement program
    d. Applying health service utilization models to the Texas Health Transformation and Quality Improvement Program: Advancing theory-based evaluation

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 RHP anchor calls.
4. HHSC recruitment and selection of Research Specialist V candidates are ongoing. Several interviews were conducted.
5. HHSC SDS traveled to San Antonio, November 5, 2014, to meet with RHP 6 members regarding their white paper proposal to evaluate efforts to reduce hospital readmissions.

6. HHSC SDS evaluation staff met with analysts from National Academy for State Health Policy (NASHP), Strategic Policy Solutions, and the Medicaid and CHIP payment and Access Commission (MACPAC) on November 4, 2014.

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 SDS submitted a data request to EQRO to Institute for Child Health Policy (ICHP). The requested data will allow HHSC to leverage qualitative data captured through the Consumer Assessment of Health Providers and Systems (CAHPS) surveys and Healthcare Effectiveness Data and Information Set (HEDIS) measures for waiver evaluation activities.

Intervention II

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 Delivery System Reform Incentive Payment (DSRIP) projects integrating primary care into behavioral health settings for adults with severe and persistent mental illness (SPMI). The HHSC legal department is currently amending the contract with Texas A&M to include this new scope of work.
2. HHSC SDS continued categorizing RHP needs as identified in the community needs assessment. This analysis allows for identification of categories of needs across the state.

Texas A&M Evaluation Activities: Intervention II

Evaluation Goal 5

1. Texas A&M team met to discuss interim report modifications in light of limited post-implementation data provided by HHSC.
2. Texas A&M team consulted with Dr. Mike Morrisey regarding previous studies of hospital behavior under cost-shifting arrangements and likely impact on uncompensated care (UC) claims.
   Dr. Morrisey holds a Ph.D. in Economics and has research expertise in hospital economics, health services administration, and health care organization and policy. His latest book, *Health Insurance*, was published in 2014 and can be found at https://www.ache.org/publications/product.aspx?pc=2253

Evaluation Goals 6-8

1. Wave 1 phone surveys were initiated for Site 03. As of December 31, 2014, 61 people from Site 03 had participated.
2. Wave 2 phone surveys were completed on November 3, 2014. From the 509-person call attempts, 298 people participated, and 181 people could not be reached (phone disconnected, call blocking, wrong number, etc.).
3. Six professionals, and two patient/family members, were interviewed at Site 07 on December 16-18, 2014.
4. As a courtesy to each DSRIP and concurrent comparison site (21), a de-identified report detailing preliminary findings from the Texas A&M was sent to each site. The de-identified report included a comparison to similar participating sites. Sites were grouped into four categories: "large urbans" (n=8), "small rurals" (n=5),"LMHA-based" (n=4), and "EMS-based" (n=4).
5. Follow-up phone calls were made to key informants at three sites, as Year 2 of the Texas A&M data collection began. One additional site reported that their hospital facility was closing December 31, 2014, and hence their DSRIP care navigation project's participation in our case study.

Evaluation Goal 9

1. A continuing review application was completed and approved for Texas A&M protocol # IRB2013-0744D.
2. Texas A&M continued data cleaning and analysis for each RHP.
3. Texas A&M began preparation of the draft interim report on overall collaboration and specific types of collaboration (sharing programs and services, sharing tangible resources, and data sharing), including an analysis of changes in collaboration from 2011 to 2013.

Evaluation Goal 10-11

1. A continuing review application was completed and approved for Texas A&M protocol # IRB2013-0744D.
2. Texas A&M completed quantitative and qualitative analyses and began preparation of the technical report to be submitted to HHSC in the next quarter.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

1. Six of the ten total site visits were completed by December 31, 2014. These visits included a total of 37 staff interviews and 41 focus group participants.
2. Two of the sites initially selected for inclusion in this study were replaced to keep the method of care integration (i.e., reverse colocation) consistent across projects.

Challenges or Issues Encountered

None.

C. ACTIVTIES PLANNED IN NEXT QUARTER

(January 1, 2015 through March 31, 2015)

HHSC SDS will attend project meetings and monthly CMS calls.

1. HHSC SDS and Texas A&M will continue to meet semi-monthly to collaborate and provide feedback on each other's evaluations.
2. 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.
3. 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.

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 continue planning for the April 24, 2015, External Evaluator's Meeting in Austin, Texas.
2. 2012 and beyond UC data is cost based, and requires application of charge-to-cost ratios to convert pre-2012 (2008-2011) charges to post 2012 costs, and perhaps vice versa, depending on which approach provides the highest validity.
3. A draft outline of the interim report for Evaluation Goal #5 will be modified based upon input from HHSC SDS leadership, and the limitation of only DY1 data available for analysis.
4. Follow-up phone interviews (one-year post original data collection) of key informants at each site will continue.
5. Data collection for wave 2 of the patient telephone surveys will continue.
6. Data analyses on the inter-organizational network survey will continue and be finalized.

7. A final technical report of results for Evaluation Goals (EGs) 10 & 11 will be submitted to HHSC.
8. Preparation will begin for the next, and final, round of data collection under (EG) 9 (data collection will commence in November 2015).
9. The HHSC SDS team and the Texas A&M team will discuss the possibility of conducting additional phone interviews as follow-up to the member and stakeholder survey (EG 10-11).
10. Preparation of the Interim Report will continue; a draft interim report of results for EG 5 through EG 11 will be submitted to HHSC.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

The remaining site visits will be completed in January 2015, with two of the focus groups occurring in February or March given delays in the implementation timeline of these participating sites (e.g., contract delays, hiring issues).

XII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

In SFQ1, HHSC designed a Category 3 Baseline reporting template. Baseline reporting templates specific to each of the 20 RHPs were posted on the HHSC website for providers to complete and submit during October DY3 reporting in order to earn payment for the DY3 Category 3 process milestone. During the review of baseline template submissions, HHSC staff provided a significant amount of technical assistance to providers who submitted requests for alternate achievement levels, reported low volume denominators, had low or high baseline performance compared to benchmarks, and/or did not submit the appropriate forms. Category 3 baseline review continued into SFQ2.

In SFQ1, CMS provided guidance on the Category 4 optional Reporting Domain 6 (RD-6) and HHSC sent providers who are reporting RD-6 a crosswalk of measure descriptions with additional guidance for reporting measures that changed in the 2014 CMS Core Set. On Reporting Domain 4, Medication Management, CMS also provided guidance for those hospitals that indicated their medication reconciliation process differs from NQF-0646, and HHSC updated the October DY3 Reporting Companion document accordingly. During SFQ1, CMS also reviewed other requests from providers for variances from Category 4 reporting requirements. In SFQ1, HHSC received Category 4 RHP level information from the EQRO on the potentially preventable admission and potentially preventable readmission reports that were provided for DY3 reporting. These were posted on the HHSC website with a summary report prepared by HHSC staff.

In SFQ1, HHSC continued reviewing the nearly 2,000 RHP plan modification and technical change requests that were submitted by DSRIP providers in July and August of FFY2014 SFQ4. These change requests included changes to project narratives and to project milestones/metrics in DYs 4 and 5. HHSC comments and preliminary determinations were provided to DSRIP providers in November, and providers were asked to respond to HHSC comments in December.

Preparing for and processing October DY 3 DSRIP reporting was a large focus of SFQ1. The web-based reporting system that had been in development for several months was implemented successfully for DY3 October reporting. Providers were able to complete their reporting in the online database and upload their documentation to support metric achievement. HHSC staff held 3 webinars to assist with October reporting and posted the recorded videos and presentations on the HHSC website.

HHSC realized that given the volume and complexity of DSRIP reporting anticipated in October, HHSC staff would be unable to review every metric and measure reported in October during the 30 days allowed for HHSC and CMS review. HHSC requested that due to the volume of projects and metrics, there be a new approach in October for managing the volume of reports. CMS worked with HHSC to add language to the Program Funding and Mechanics (PFM) Protocol to specify that HHSC and CMS may determine that a subset of not less than half of the projects and metrics will be reviewed during the 30 days after the reporting period. In such instances, HHSC and CMS will designate those projects and metrics that are not reviewed within 30 days as “provisionally approved.” Such “provisionally approved” projects and metrics will be reviewed in full by HHSC prior to the next reporting due date in April 2015. For metrics that are “provisionally approved,” the Performing Provider will receive full DSRIP payment in January 2015. After review of any “provisionally approved” item, additional information regarding the data reported for each milestone/metric will be requested if necessary, most likely in late February or early March 2015. If the initial supporting documentation, and any additional information, does not form a sufficient basis for actual metric achievement, HHSC will recoup the associated overpayments from the Performing Provider. As described in waiver rules, HHSC will withhold future payments until the recoupment occurs. Those providers who had metrics that needed more information before they could be approved were able to submit additional documentation in December and January, and they received final feedback in SFQ2.

In SFQ1, HHSC sent out all formal anchor contracts for administrative costs. HHSC conducted a technical assistance session in October for anchors participating in administrative claiming to discuss timelines, cost principles, the Percent of Effort spreadsheet and the cost template. These documents were all posted on the HHSC website. The due date for the DY2 anchor cost claiming report was November 30, 2014. Anchors could also submit their DY3 costs with the DY2 invoice or carry them forward to the next invoice period.

HHSC continued working with Myers & Stauffer, LLP, the independent assessor conducting the midpoint assessment and ongoing compliance monitoring. Six hundred and seventy-seven projects were selected for the midpoint assessment review based on the following: a) project options that were requested to be reviewed by CMS (1.10, 2.4, 2.5 and 2.8 and projects that were approved under "other" project option); b) projects flagged by HHSC during approval, plan modification and reporting reviews; and c) projects selected via random sampling. Myers & Stauffer began with in-depth desk reviews and also conducted on-site visits with selected providers.

HHSC continued stakeholder communications in SFQ1 through webinars, biweekly Anchor calls, Executive Waiver Committee meetings, and companion documents. HHSC conducted webinars to provide technical assistance to DSRIP providers for reporting Quantifiable Patient Impact (October 1, 2014), for assistance with Category 3 baseline reporting (October 2, 2014) and general reporting guidance for October DY3 reporting, including how to use the new DSRIP automated reporting system (October 6, 1014). On November 6, 2014, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, including the Uncompensated Care deferral from CMS, waiver amendments submitted to CMS regarding the use of unspent DSRIP DY2 funds, and a discussion of waiver renewal, including the Transition Plan for Funding Pools due to CMS in March 2015. HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2015 SFQ2.

ENCLOSURES/ATTACHMENTS

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

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

Attachments C1-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 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 Health Plans. 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.

STATE CONTACTS

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

Ardas Khalsa
Deputy Medicaid/CHIP Director, Healthcare Transformation Waiver Operations and Cost Containment
Texas Health and Human Services Commission
4900 N Lamar Blvd.
Austin, TX 78751
(512) 707-6105
Fax (512) 491-1971
ardas.khalsa@hhsc.state.tx.us

For all other questions regarding the waiver, please contact:

Becky Brownlee
Director, Texas Health and Human Services Commission
4900 N Lamar Blvd.
Austin, TX 78751
(512) 462-6281
Fax (512) 730-7472
becky.brownlee@hhsc.state.tx.us

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ACRONYM LIST

AAA	area agency on aging
ADRC	Aging and Disability Resource Centers
APHA	American Public Health Association
BIP	Balancing Incentive Program
CAHPS	Consumer Assessment of Health Providers and Systems
CAP	corrective action plan
CFC	Community First Choice
CMS	Centers for Medicare & Medicaid Services
DADS	Department of Aging and Disability Services
DMO	dental managed care organization
DSH	Disproportionate Share Hospital
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	demonstration year
EB	enrollment broker
EG	evaluation goal
ENT	otolaryngologist
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	emergency room
ERS	emergency response services
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HPM	Health Plan Management
HSRI	Human Services Research Institute
ICF-IID	intermediate care facility for individuals with intellectual disabilities or a related condition
ICHP	Institute for Child Health Policy
ICSS	Independent Consumer Supports System
IGT	intergovernmental transfer
IMD	institution for mental disease
LD	liquidated damages
LTCO	long-term care ombudsman
MACPAC	Medicaid and CHIP payment and Access Commission
MAGI	modified adjusted gross income
MCO	managed care organization
MMCH	Medicaid Managed Care Helpline
MRSA	Medicaid Rural Service Areas
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NASHP	National Academy for State Health Policy
NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators-Aging and Disabilities
OON	out-of-network
P4Q	Pay-For-Quality
PBM	Pharmacy Benefits Manager
PIP	performance improvement project
PCP	primary care provider
PFM	Program Funding and Mechanics
RHP	Regional Healthcare Partnerships
SDA	service delivery area

SDS	HHSC Strategic Decision Support
SFQ	State Fiscal Quarterly
SMMC	State Medicaid Managed Care Advisory Committee
SPMI	severe and persistent mental illness
STCs	Special Terms and Conditions
TCH	Texas Children’s Hospital
TCHP	Texas Children’s Health Plan
THSteps	Texas Health Steps
UC	uncompensated care