

Texas Healthcare Transformation and Quality Improvement Program Section 1115 Combined Annual and Quarterly Report

Demonstration Reporting Period:

Demonstration Year: 1 (12/10/2011 – 9/30/2012)

Federal Fiscal Quarter: 4/2012 (7/1/2012 – 9/30/2012)

I. Introduction

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

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

This report combines annual and quarterly reporting requirements for the STAR, STAR+PLUS and Children’s Medicaid Dental Services programs, and addresses Standard Terms and Conditions (STCs) 24(e), 39(a) and (c), 40(b) and (c), 52, and 65.

In this report, the State will address the annual reporting requirements in STCs 24(e), 40(b) and 39(c), regarding managed care network adequacy and capacity. STC 39(c) also includes annual requirements regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and outcomes. Because the CAHPS results are not finalized, the State will provide a separate report on the external quality review organization’s findings no later than the January 28, 2013 due date.

This report also addresses the quarterly reporting requirements found in STCs 39(a), 52 and 65, which require the State to report on various topics, including: enrollment; outreach; encounter data; operational, policy, systems, and fiscal issues; action plans for addressing 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 information presented in this report is based on data compiled for SFQ4 (June-August) instead of Demonstration Period 4 (Q4, covering July-September). For annual reporting requirements, the State has included managed care data for SFQ2 through SFQ4 (December-August), representing the portions of State Fiscal Year (SFY) 2012 covered by Demonstration Year 1 (DY1). Throughout the report, the State has identified whether the quarterly data relates to SFQ4 or Q4, and whether the annual data relates to SFY 2012 or DY1.

A. Managed Care Plans Participating in the Waiver Programs

The State has contracted with 18 STAR plans and 5 STAR+PLUS plans. All of these plans cover one or more of the 13 STAR service areas or 10 STAR+PLUS service areas. The following table identifies these plans by service area.

Figure 1: STAR and STAR+PLUS Plans by Service Area

Service Area	STAR	STAR+PLUS
Bexar	Aetna Better Health Amerigroup Texas Community First Health Plans Superior HealthPlan	Amerigroup Texas Molina Healthcare of Texas Superior HealthPlan
Dallas	Amerigroup Texas Molina Healthcare of Texas Parkland Comm. Health Plan	Molina Healthcare of Texas Superior HealthPlan
El Paso	El Paso First Health Plan Molina Healthcare of Texas Superior HealthPlan	Amerigroup Texas Molina Healthcare of Texas
Harris	Amerigroup Texas Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan UnitedHealthcare Community Plan	Amerigroup Texas Molina Healthcare of Texas UnitedHealthcare Community Plan
Hidalgo	Driscoll Children's Health Plan Molina Healthcare of Texas Superior HealthPlan Network UnitedHealthcare Community Plan	HealthSpring Life & Health Ins. Co. Molina Healthcare of Texas Superior HealthPlan
Jefferson	Amerigroup Texas Community Health Choice Molina Healthcare of Texas Texas Children's Health Plan UnitedHealthcare Community Plan	Amerigroup Texas Molina Healthcare of Texas UnitedHealthcare Community Plan
Lubbock	Amerigroup Texas FirstCare HealthPlans Superior HealthPlan	Amerigroup Texas Superior HealthPlan
MRSA Central	Amerigroup Ins. Co. Scott & White Health Plan Superior HealthPlan Network	
MRSA Northeast	Amerigroup Ins. Co. Superior HealthPlan Network	
MRSA West	Amerigroup Ins. Co. FirstCare HealthPlans Superior HealthPlan Network	
Nueces	CHRISTUS Health Plan Driscoll Children's Health Plan Superior HealthPlan	Superior HealthPlan UnitedHealthcare Community Plan
Tarrant	Aetna Better Health Amerigroup Texas Cook Children's Health Plan	Amerigroup Texas HealthSpring Life & Health Ins.
Travis	Health Care Services Corp./BCBS Sendero Health Plans Seton Health Plan Superior HealthPlan	Amerigroup Texas UnitedHealthcare Community Plan

Additionally, three dental plans provide services to clients in the Children's Medicaid Dental Services program (also referred to as the Children's Dental Program in STC 40): Delta Dental Insurance Company, DentaQuest USA Insurance Company, Inc., and MCNA Insurance Company. As discussed in Section V of this report, Delta Dental Insurance Company will no longer participate in the program effective December 1, 2012.

B. 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 will 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. During Q4, the Texas Health and Human Services Commission (HHSC) continued negotiations with CMS and received federal approval of the Program Funding and Mechanics (PFM) Protocol on August 31, 2012, and the RHP Planning Protocol on September 26, 2012. HHSC continues engaging Anchors, Performing Providers, IGT Entities, and other stakeholders to complete RHP Plans no later than December 31, 2012.

II. Enrollment and Benefits Information

This section addresses the quarterly reporting requirements from STCs 65 and 39(a), as well as the annual reporting requirements found in STCs 24(e) and 40(b). In this section, the State will address trends and issues related to STAR, STAR+PLUS and Children's Medicaid Dental Services eligibility and enrollment; disenrollment from managed care; access to care and managed care delivery networks; anticipated changes in populations and benefits; and enrollment counts for the Demonstration quarter. The primary source of information for this section is the Managed Care Organization Quarterly Performance Status Reports (the "managed care quarterly reports"), which are compiled by HHSC's Health Plan Management staff on a SFQ cycle. Unless otherwise provided, annual managed care data covers the SFQ2 through SFQ4 reporting periods (December-August), and quarterly managed care data covers the SFQ4 reporting period (June-August 2012).

A. Eligibility and Enrollment

This subsection addresses the quarterly reporting requirements found in STC 65, and annual requirements from STC 24(e) and 40(b). Attachment A provides supporting data for this subsection, and includes annual and quarterly enrollment summaries for the three Waiver programs.

1. SFQ4 Enrollment Data

As indicated in Attachment A, enrollment remained fairly consistent from SFQ3 to SFQ4, trending within normal and seasonal fluctuations. There was less than a one percent change in overall STAR (-.70 percent) and STAR+PLUS (.11 percent) program enrollment. Enrollment in Children's Medicaid Dental Services grew at a slightly higher rate of 2.02 percent.

Ten out of 18¹ STAR plans had small to moderate decreases in overall plan enrollment from SFQ3 to SFQ4, ranging from .23 to 5.25 percent. The remaining eight STAR plans had variable growth, ranging from .18 to 17.24 percent.

Overall plan enrollment fell for two of five STAR+PLUS plans in SFQ4. United and Molina experienced 1.93 and 8.54 percent losses, respectively. The remaining three plans gained membership, ranging from 1.12 to 8.61 percent.

One dental plan experienced a 6.93 percent loss in enrollment in SFQ4, while the remaining two experienced comparable gains of 6.71 and 8.06 percent.

Attachment A also includes market share summaries for each program. From SFQ3 to SFQ4, STAR market shares changed very minimally. Shifts were greater in STAR+PLUS, impacting two PLANs more than the others. Molina had a 2.4 percent decrease in market share (a net loss of 9,452 members), and Superior had a 2 percent increase (a net gain 8,044 members). A large portion of this shift occurred in the Hidalgo service area, due in part to Molina's decision to reduce some provider rates. This decision and resulting stakeholder reaction is addressed in further detail in Section V(A) of this report.

All three dental plans experienced moderate shifts in the Children's Medicaid Dental Services market share. Delta Dental's market share decreased by 3.23 percent, reflecting a loss of over 62,991 members. Some of this loss is attributed to Delta Dental's enrollment suspension, which ended in August 2012. DentaQuest's and MCNA's market shares rose by 1.73 percent and 1.51 percent, reflecting net gains of 62,044 and 50,625 members.

The following three charts depict the statewide distribution of STAR, STAR+PLUS, and Children's Medicaid Dental Services membership as of the last day in SFQ4.

¹ Results are consolidated for the following affiliated companies: (1) Amerigroup Texas and Amerigroup Ins. Co., and (2) Superior HealthPlan and Superior HealthPlan Network.

Figure 2: STAR Program – SFQ4 Market Share

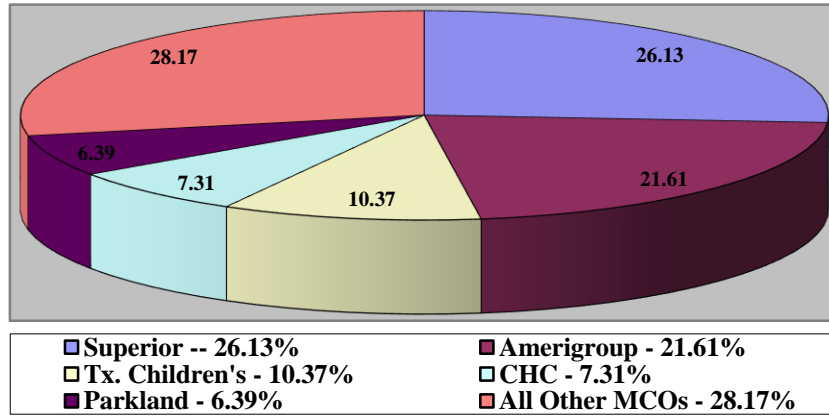


Figure 3: STAR+PLUS Program – SFQ4 Market Share

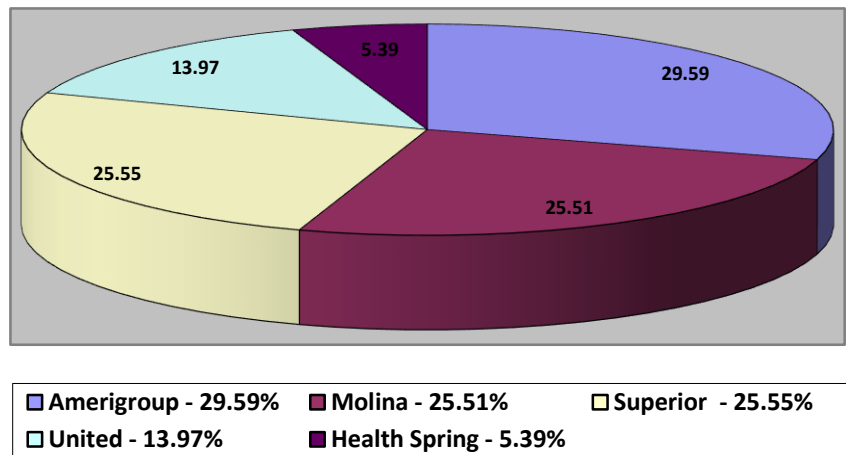
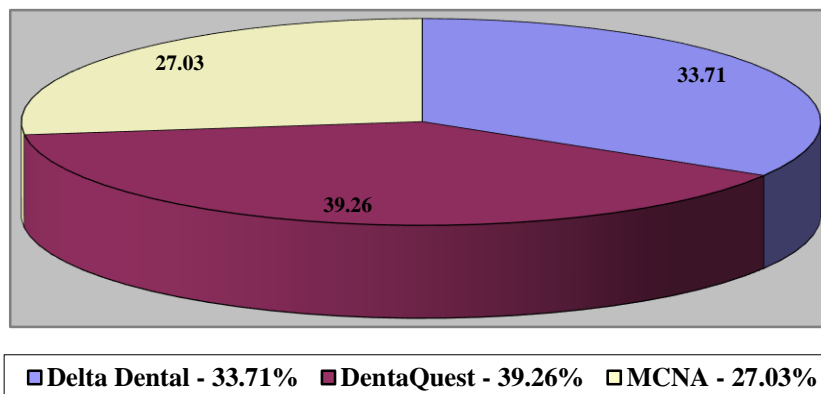


Figure 4: Children's Medicaid Dental Services – SFQ4 Market Share

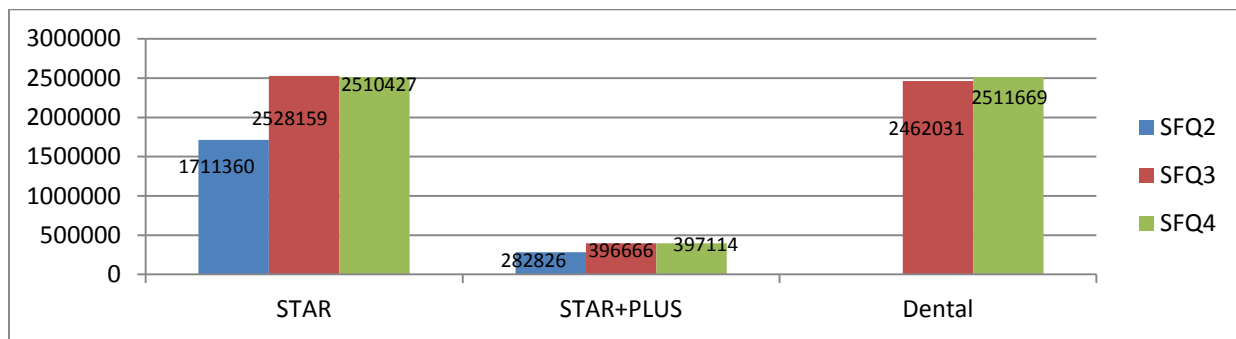


2. Annual Enrollment Data

Although total enrollment stabilized from SFQ3 to SFQ4, overall enrollment grew significantly from the first to last reported quarter in the Demonstration (SFQ2 to SFQ4). Much of this growth can be attributed to the addition of new STAR and STAR+PLUS service areas and implementation of the Children's Medicaid Dental Services program in March 2012.

From SFQ2 to SFQ4, STAR and STAR+PLUS enrollment grew by 46.69 percent and 40.41 percent, respectively. From SFQ3 to SFQ4, enrollment in Children's Medicaid Dental Services grew by 2.02 percent. The following chart tracks program growth in the first three SFQs of DY1.

Figure 5: Annual Enrollment Changes for STAR, STAR+PLUS and Children's Medicaid Dental Services



As shown in Attachment A, only 2 of 18 STAR plans experienced a net loss in membership from SFQ2 to SFQ4, Community First (10.27 percent) and El Paso First (4.38 percent). The remaining 16 plans experienced small to significant growth, ranging from .58 to 477.03 percent.

One STAR+PLUS plan had a small loss in membership from SFQ2 to SFQ4. United's enrollment decreased by .78 percent, a net loss of 434 members. The remaining four STAR+PLUS plans had substantial growth, ranging from 18.88 to 520.71 percent.

As discussed above, only one dental plan lost membership during the Demonstration year, Delta Dental with a 6.93 percent loss. The remaining two dental plans had 6.71 and 8.06 percent growth. These changes resulted in moderate shifts in market share, as described above.

As indicated in Attachment A, market shares shifted for many of the healthcare plans from SFQ2 to SFQ4, with the addition of new STAR and STAR+PLUS service areas and the introduction of new STAR plans. These shifts were largely offset by the influx of new membership, as reflected in overall program growth for most STAR and STAR+PLUS plans.

B. Disenrollment from Managed Care

This subsection addresses the quarterly reporting requirements found in STC 65, regarding managed care clients' requests for disenrollment.

HHSC tracks disenrollment requests through the Health and Human Services Enterprise Administrative Report and Tracking systems. For the second consecutive quarter, the State did

not receive any disenrollment requests for Children’s Medicaid Dental Services. Disenrollment requests rose for STAR, but decreased for STAR+PLUS in SFQ4.

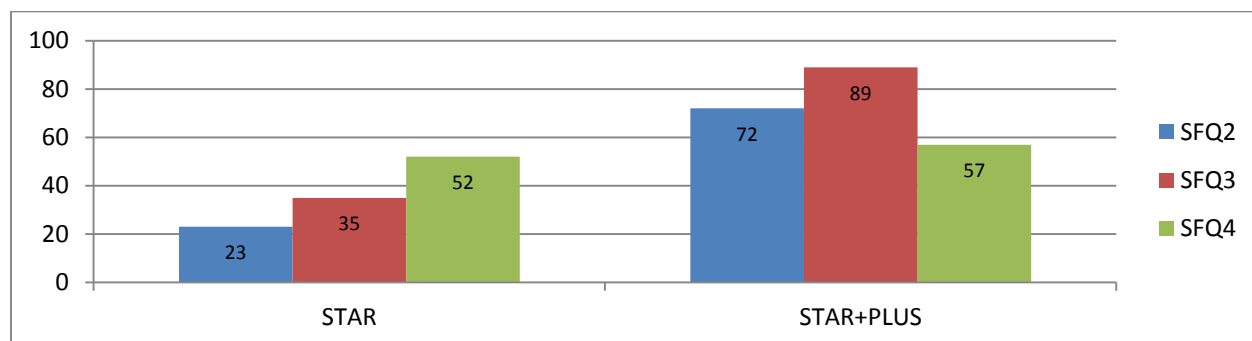
The State received 52 disenrollment requests for STAR in SFQ4 – one initiated by a plan and the remaining 51 by members. The State’s two largest STAR plans, Amerigroup and Superior, received the most disenrollment requests.

The State also received 57 STAR+PLUS disenrollment requests, all initiated by members. The three largest STAR+PLUS plans received the majority of disenrollment requests -- Amerigroup, Superior, and Molina.

For both programs, the majority requests were based on the member selecting a provider that was not in the plan’s network. The State was able to close most disenrollment cases after the plan helped the member locate an alternative network provider, or entered into a single case agreement with the member’s out-of-network provider.

The following chart depicts total disenrollment requests during the first three SFQs of DY1.

Figure 6: Managed Care Disenrollment Requests – SFQ2 through SFQ4



Although the number of disenrollment requests rose in STAR, the ratio of disenrollment requests to members remained low in STAR and STAR+PLUS in SFQ4. In STAR, there was one disenrollment request per 48,277 members, and one per 6,967 members in STAR+PLUS.

C. Access to Care/Managed Care Delivery Networks

This subsection addresses the quarterly reporting requirements found in STCs 39(a) and 65, and annual requirements from STC 24(e) and 40(b). It includes quarterly and annual healthcare and pharmacy provider counts for STAR and STAR+PLUS, and dental provider counts for Children’s Medicaid Dental Services. It also addresses the numbers of primary care physicians (PCPs) and main dentists accepting new members; State and plan GeoMapping results; service utilization; and use of out-of-network providers. The primary source of data for this subsection is the managed care quarterly reports, State analysis, and self-reported data from the plans. Supporting data is located in Attachments B through I.

1. STAR and STAR+PLUS Provider Counts for SFQ4

Attachment B shows that provider terminations decreased for STAR, but increased for STAR+PLUS in SFQ4. STAR terminations decreased by over 13 percent, down from 2,961 in

SFQ3 to 2,572 in SFQ4. STAR+PLUS terminations increased by over 24 percent, up from 912 in SFQ3 to 1135 in SFQ4. These numbers represent total termination counts, and have not been reduced to account for providers who terminated network agreements with more than one plan or program.

STAR and STAR+PLUS plans reported various reasons for provider terminations in SFQ4, most commonly: provider moved, retired, or left a group practice; provider requested the termination; provider placed on inactive status; and provider close practice or retired.

Although all STAR and STAR+PLUS plans reported terminations in SFQ4, provider recruitment generally compensated for these losses. Total network participation rose for the third consecutive quarter. As a whole, STAR plans increased total network enrollment by 15.81 percent from SFQ3 to SFQ4, and STAR+PLUS plans increased enrollment by 14.88 percent.

Network participation grew for most STAR and STAR+PLUS plans in one or more service areas in SFQ4. Out of 45 STAR and 24 STAR+PLUS service areas reported, network participation increased or remained stable for:

- All providers in 41 STAR and all 24 STAR+PLUS areas;
- PCPs in 36 STAR and 22 STAR+PLUS areas; and
- Specialists in 42 STAR and all 24 STAR+PLUS areas.

All STAR and STAR+PLUS plans with net PCP losses maintained acceptable ratios of members to PCPs.

As indicated in Attachment C, STAR and STAR+PLUS plans' pharmacy networks were normally stable in SFQ4. The total pharmacy provider counts grew slightly in both programs from SFQ3 to SFQ4, increasing by .98 percent in STAR and .26 percent in STAR+PLUS.

Out of 45 STAR and 24 STAR+PLUS service areas, pharmacy network participation increased or remained stable for:

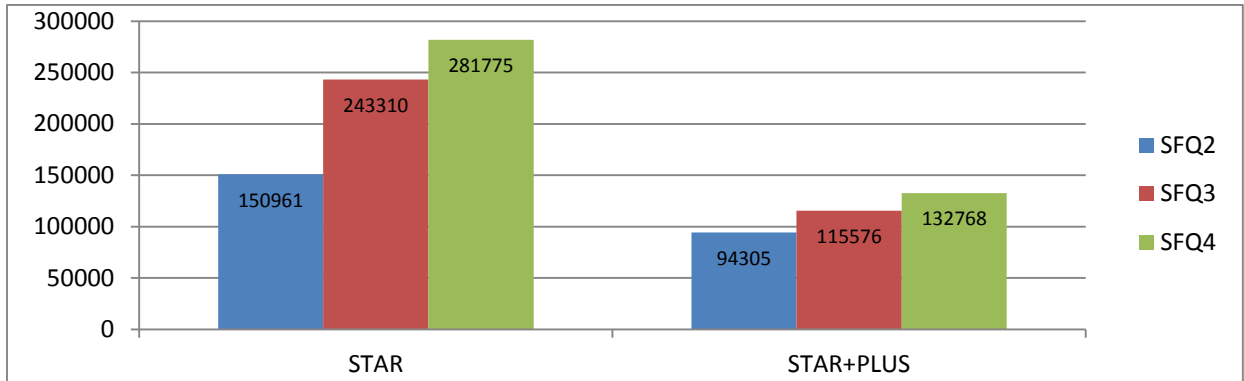
- All pharmacy providers in 38 STAR and 19 STAR+PLUS areas;
- 24-hour pharmacies in all 45 STAR and 19 STAR+PLUS areas; and
- Mail order pharmacies in all 45 STAR and all 24 STAR+PLUS areas.

The service areas that lost the most pharmacy providers were Hidalgo (16) and Tarrant (8) for STAR, and Hidalgo (8) and Jefferson (7) for STAR+PLUS. These numbers represent total provider counts, and have not been reduced to account for providers who terminated pharmacy network agreements with more than one plan or program.

2. STAR and STAR+PLUS Annual Provider Counts

Both STAR and STAR+PLUS showed substantial network growth from SFQ2 to SFQ4, as depicted in the following table.

Figure 7: Total Healthcare Provider Enrollment for All Plans – SFQ2 to SFQ4



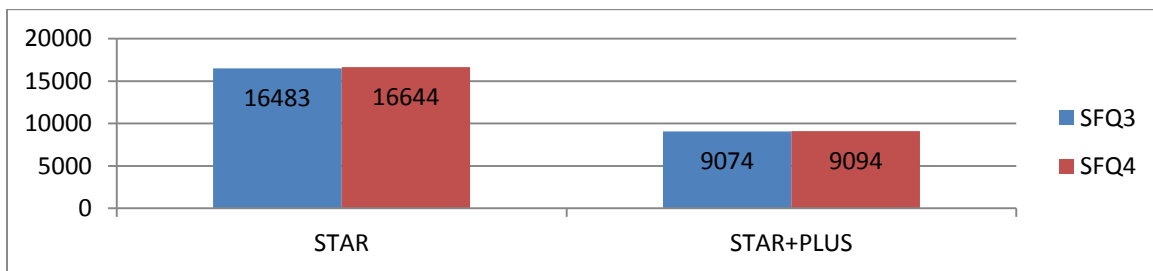
Attachments B, D, and E include the STAR and STAR+PLUS network summaries for the first three SFQs in the Demonstration. These attachments include duplicated provider counts, meaning that providers who are enrolled in more than one plan’s network are included in each plan’s total network counts.

From SFQ2 to SFQ4, the total provider count increased by 86.65 percent for STAR and 40.79 percent for STAR+PLUS. Both programs showed significant network increases for both PCPs and specialists. PCP participation in STAR rose by 103.06 percent, and in STAR+PLUS by 36.17 percent. Specialist participation rose by 102.18 percent in STAR, and 44.38 percent in STAR+PLUS.

Some network growth is attributed to the March 1, 2012 expansion of STAR and STAR+PLUS into new service areas; however, total network participation also increased in the historical service areas. In pre-expansion service areas, STAR provider enrollment increased by 27.81 percent from SFQ2 to SFQ4, and STAR+PLUS by 17.16 percent.

As described above, total pharmacy network participation also grew modestly in the two quarters following the March 1, 2012 pharmacy carve-in. The following chart tracks this growth.

Figure 8: Total Pharmacy Provider Enrollment for All Plans – SFQ3 to SFQ4



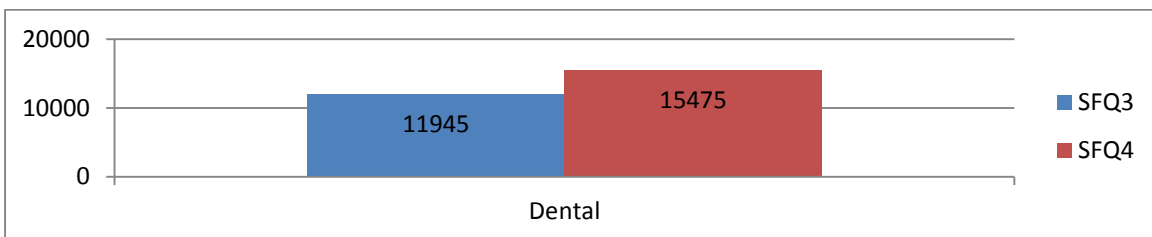
3. Quarterly and Annual Provider Counts for Children’s Medicaid Dental Services

In Children’s Medicaid Dental Services, provider terminations dropped by over 43 percent in SFQ4. Dental plans reported a total of 176 terminations in SFQ4, including 135 main dentists. This is down from SFQ3, where dental plans reported 311 terminations, 280 of which were main dentists. These are aggregate counts, and have not been reduced to account for network providers that may have left more than one dental network. The most common reasons for termination in the dental program were: provider placed on inactive status; provider moved; and the provider requested termination.

As indicated in Attachment B, dental plans continued to actively recruit providers, resulting in a significant boost in network enrollment. All three dental plans had sizeable increases in total provider counts, ranging from 19.70 percent to 52.53 percent growth. All three grew their specialist networks by 6.26 to 96.30 percent. Only one dental plan experienced a net loss in main dentists, Delta Dental with a 5.23 percent decrease. The remaining two dental plans increased participation by 21.00 and 80.76 percent. The three dental plans had a combined growth of 3,530 total providers, of which 2,167 were main dentists and 1,363 were specialists.

The following table demonstrates this growth by comparing the total provider counts for SFQ3 to SFQ4, the first two operational quarters following the March 1, 2012 dental expansion.

Figure 9: Total Provider Counts for Children’s Medicaid Dental Services – SFQ3 to SFQ4



All three dental plans met the State’s 90 percent standard for main dentists with open practices in SFQ3 and SFQ4, and maintained acceptable ratios of members to main dentists.

4. Primary Care Providers and Main Dentists Accepting New Members

This part addresses annual reporting requirements found in STC 24(e) and 40(b), regarding the number of network providers accepting new Demonstration populations. Supporting data is located in Attachments B, D, and E.

STAR and STAR+PLUS plans submit quarterly files identifying the number of PCPs who are accepting new Medicaid patients, or “open panel” PCPs. Likewise, dental plans identify number of main dentists accepting new Medicaid patients, or “open practice” dentists.

The State does not track the number of specialty providers accepting new patients, which is consistent with the Texas Department of Insurance’s network review practices. To determine whether the plans have adequate specialist networks, HHSC monitors member and provider complaints; and tracks total network participation, GeoMapping results, and out-of-network utilization. Other sections of this report track these monitoring results.

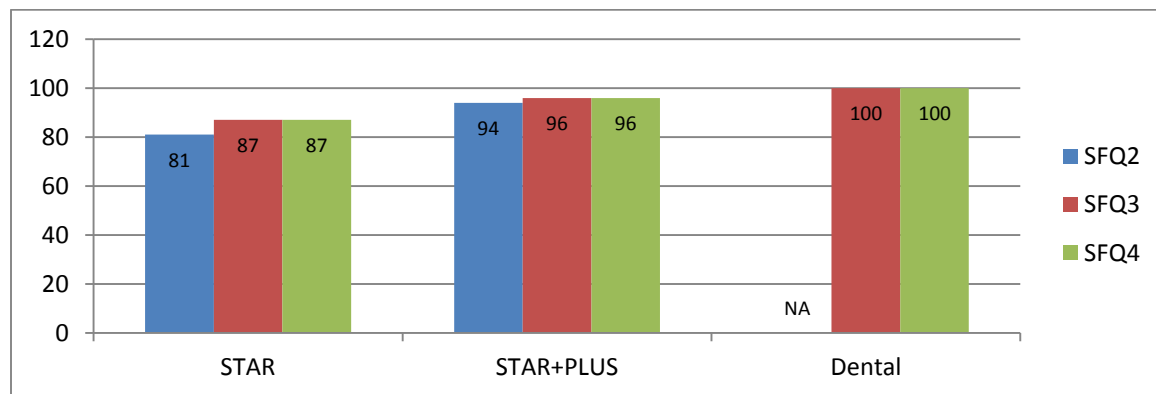
When determining the adequacy of STAR and STAR+PLUS PCP networks, one of the factors the State reviews is whether at least 80 percent of a plan’s PCPs have an open panel. The standard is higher for main dentists, where the State applies a 90 percent benchmark.

During the first three quarters in the Demonstration, most plans met these program benchmarks. In SFQ2, STAR plans were able to demonstrate that at least 80 percent of their PCP networks had an open panel in 22 of 27 reported service areas, and 16 of 17 STAR+PLUS service areas. In SFQ3 and SFQ4, STAR and STAR+PLUS plans reported similar results. In both SFQ3 and SFQ4, STAR plans showed compliance in 39 of 45 service areas. Likewise, only one STAR+PLUS plan failed to meet the benchmark in both SFQ3 and SFQ4, resulting in compliance in 23 of 24 service areas.

The three dental plans complied with the 90 percent benchmark for main dentists in their first two operational quarters.

The following table shows overall percentage of service areas where plans met or exceeded the PCP and main dentist benchmarks from SFQ2 to SFQ4. By way of example, STAR+PLUS plans complied with the PCP benchmark in 16 out of 17 service areas in SFQ2, resulting in overall compliance in 94 percent of the reported service areas.

Figure 10: Percent of Service Areas Where Plans Met Main Dentist or PCP Benchmarks – SFQ2 to SFQ4



5. GeoMapping Results

This part includes STAR, STAR+PLUS, and Children’s Medicaid Dental Services GeoMapping results, which are quarterly and annual reporting requirements in STCs 24(e), 39(a), 40(b) and 65. Because there is a one quarter lag between the end of each SFQ and the completion of HHSC’s compliance analysis, this report presents analysis for SFQ2 and SFQ3 only. Supporting data is found in Attachments F through L.

HHSC now uses two processes to monitor GeoMapping results. Beginning with the SFQ3 data period, the State began requiring plans to self-report GeoMapping results. These reports focus on provider types commonly seen by the Demonstration population.

For the reported periods, the managed care contracts require STAR and STAR+PLUS plans to provide access to at least one provider within the following travel distances, measured from a member's place of residence:

- 15 miles – pharmacies (beginning in SFQ3);
- 30 miles – open panel PCPs and acute care hospitals; and
- 75 miles – specialists and specialty hospitals.

The Children's Medicaid Dental Services contracts require dental plans to provide access to at least two providers within the following travel distances:

- 30 miles – open practice main dentist (urban areas); and
- 75 miles – open practice main dentist (rural areas) and specialists.

In addition to the plans' self-reported GeoMapping summaries, the State's Strategic Decision Support (SDS) Unit uses plan data to create GeoMapping reports and conduct compliance analysis. Historically, SDS' quarterly analysis focused on PCPs for adults, and PCPs and otolaryngologists (ENTs) for children in the STAR and former Primary Care Case Management programs. Beginning with SFQ3 data, the State expanded this analysis to include PCPs and ENTs for children in STAR+PLUS; PCPs for adults in STAR+PLUS; STAR and STAR+PLUS pharmacies; and Children's Medicaid Dental Services providers.

a. SDS STAR Analysis for SFQ2

In SFQ2, the State applied a 90 percent benchmark to PCPs for adults and children, and ENTs for children. As documented in the State's previous waiver report and Attachment F, SDS analysis shows that STAR plans met the State's compliance benchmarks in all reported service areas in SFQ2. Almost all STAR plans provided 100 percent of their adult and child members with access to a PCP within 30 miles, and 100 percent of child members with access to ENTs within 75 miles.

b. SDS STAR, STAR+PLUS and Children's Medicaid Dental Services Analysis for SFQ3

Attachments G and H are SDS' analysis for STAR and STAR+PLUS for SFQ3. For healthcare providers, SDS calculated the percentage of child and adult members in each STAR and STAR+PLUS service area who had access to an open panel PCP within 30 miles, and the percentage of child members in these areas with access to an ENT within 75 miles. The results were very favorable, and show that all plans complied with the 90 percent benchmark for each provider type, averaging at or near 100 percent in most parts of the state.

Attachment I includes the SDS analysis for STAR and STAR+PLUS pharmacy access in SFQ3, the first quarter that includes the pharmacy carve-in. The results are also favorable, and show that as a whole, the STAR and STAR+PLUS programs provided sufficient access to pharmacies. In urban areas, 99.9 percent of members had access to one network pharmacy within 15 miles, and 97.6 of members in rural areas had such access.²

² Effective September 1, 2012, the State changed the pharmacy access requirements. The new requirements are based in part on Medicare Part D standards, and use urban, suburban, and rural indicators. Although these standards did not apply to SFQ3, the second tab in Attachment I analyzes program performance under the new standards.

Attachment I also includes the SFQ3 SDS analysis for Children's Medicaid Dental Services. With one exception, the results were also very positive. SDS' analysis shows that, as a whole, the dental program provided 100 percent of members in urban areas access to two open practice main dentists within 30 miles of residence, and 99.9 percent of member in rural areas access to two within 75 miles. As a whole, specialist access fell short of the 95 percent benchmark, with 80.2 percent of urban members having access to a specialist within 75 miles, and 73.7 percent of rural members having such access. Two of the dental plans, DentaQuest and MCNA complied with most benchmarks, but Delta Dental's compliance lowered the program average.

c. Plan's Self-Reported Data for SFQ3

In STAR and STAR+PLUS, plans reported on the percentage of members in each service area with access to the following provider types within the contract's required travel distances:

- All STAR and STAR+PLUS members: PCPs; obstetricians/gynecologists (OB/GYNs); acute care hospitals; outpatient behavioral health hospitals; pharmacies;
- All STAR+PLUS members: outpatient behavioral health services providers;
- Children in STAR and STAR+PLUS: ENTs;
- All STAR members and STAR+PLUS children: allergists/immunologists; orthopedic surgeons;
- STAR+PLUS adults: cardiologists; gastroenterologists; nephrologists; and pulmonologists.

Because Children's Medicaid Dental Services program is statewide, dental plans report on performance for 11 Texas regions. Within each region, the dental plans reported on the percentage of members in urban and rural areas with access to: main dentists; endodontists; oral surgeons; orthodontists; periodontists; and prosthodontists.

Attachments J through L are summaries of the plan's self-reported data for SFQ3. For each provider type, the plans calculated the percentage of members in each service area who had access to each provider type within the prescribed travel distances. For all STAR and STAR+PLUS provider types, the State applied a 90 percent compliance benchmark for SFQ3. The State applied different standards to the dental plans requiring them to demonstrate that all members had access to at least two main dentists within the required travel distances, and 95 percent of members had access to specialists within the required distances.

Note that number of members included in SDS' and the plans' analyses can vary greatly. This is primarily because the SDS analysis is limited to members for whom the State has a fully geocodable address in its database. The State allows the plans to use their own databases of member addresses.

Attachments J and K include the plans' self-reported GeoMapping results for STAR and STAR+PLUS. Although SDS' findings were sometimes showed higher compliance rates than the plans' self-reported results, the outcomes were generally consistent. As with the SDS findings, the STAR and STAR+PLUS plans' reports show that almost all children and adults had access to an open panel PCP within 30 miles of their homes, and almost all children had access

Again, the results are mostly positive and demonstrate that as a whole, the STAR and STAR+PLUS programs met the benchmark requirements.

to an ENT within 75 miles. With a few exceptions, all STAR and STAR+PLUS plans met or exceeded the 90 percent benchmark for these provider types. Molina did not meet the PCP benchmark for adults in the Jefferson service area, where it reported a 78.20 percent compliance rate. Amerigroup and Superior also had fell short of the 90 percent benchmark for ENTs in the Medicaid rural service areas, where Medicaid provider enrollment with the State has historically been less concentrated than in urban areas. Amerigroup reported 39.20 percent compliance for ENTs in the Northeast rural service area, and 77.20 in the West. Superior came closer to the benchmark in the West, reporting 86.20 percent compliance.

As described above, the State required the plans to report on additional specialist types that were not included in the SDS analysis. These reports show that, as a whole, STAR and STAR+PLUS members generally did not have to travel beyond the State-prescribed distances to get to most provider types. For STAR specialists, most of the exceptions occurred in the Hidalgo and three Medicaid rural service areas, where Medicaid members have traditionally had to travel farther to reach providers.

The following charts show STAR and STAR+PLUS program averages for SFQ3, based on the plans' self-reported data.

Figure 11: SFQ3 STAR and STAR+PLUS Program – Percent of Children with Access to One Provider

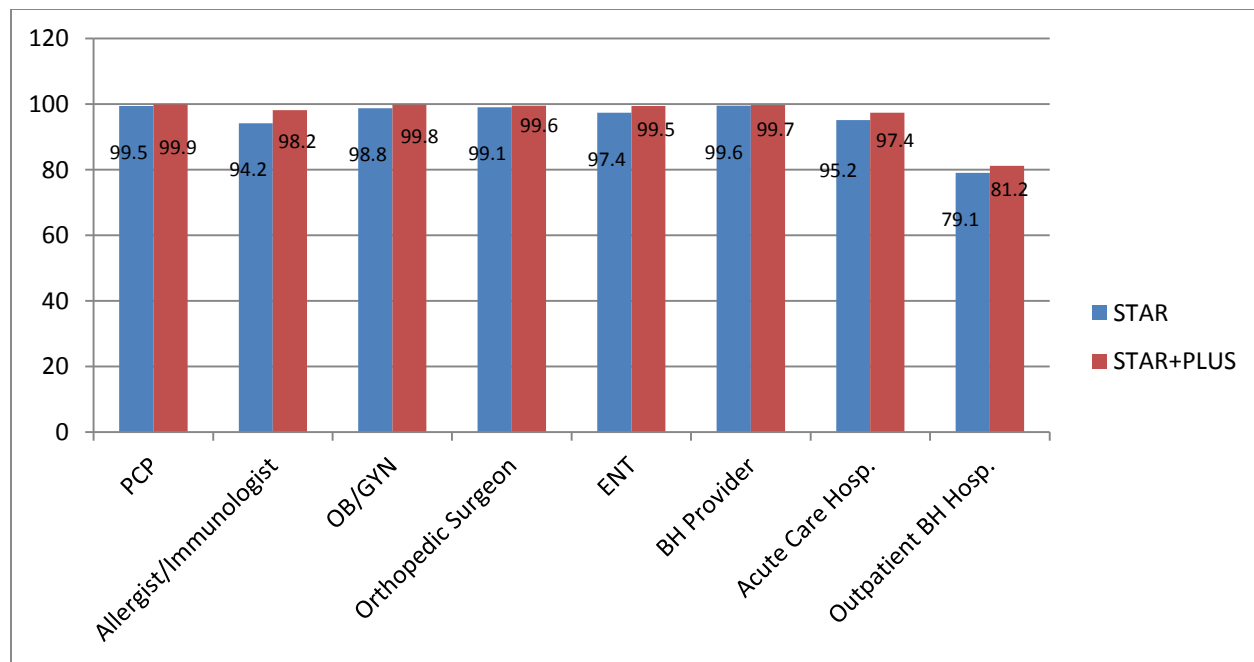


Figure 12: SFQ3 STAR Program – Percent of Adults with Access to One Provider

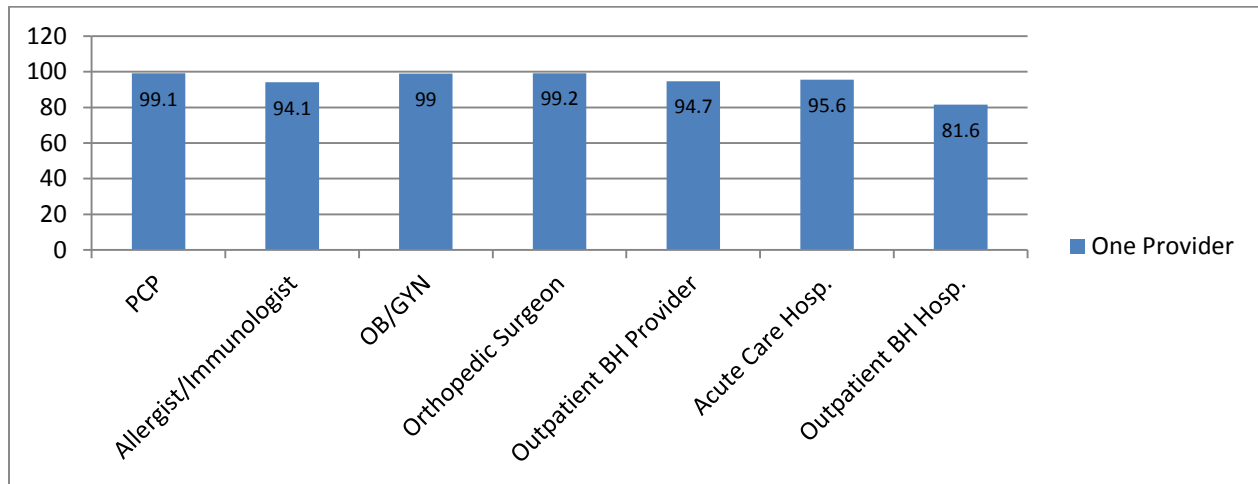
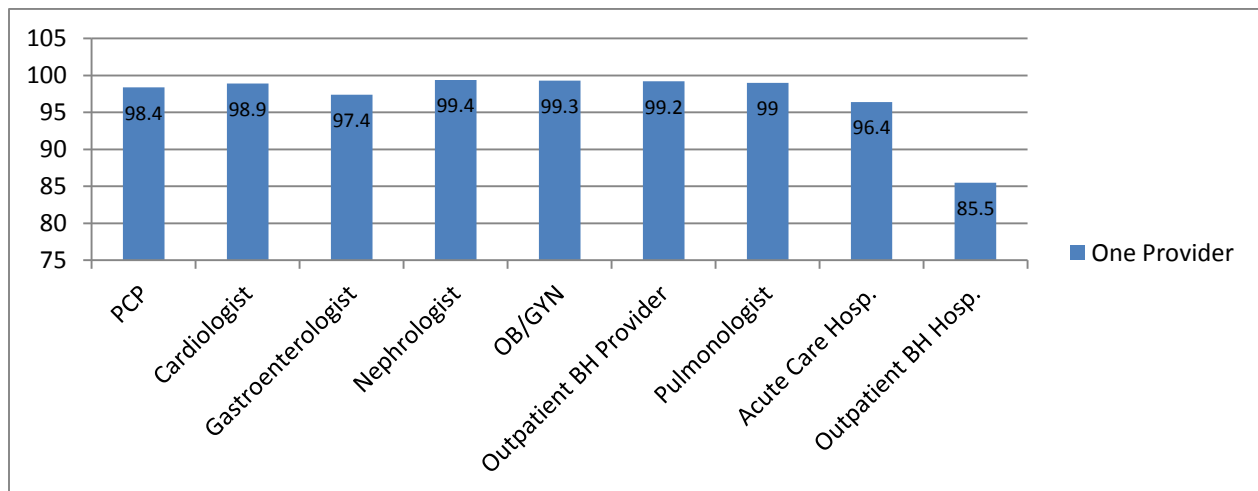


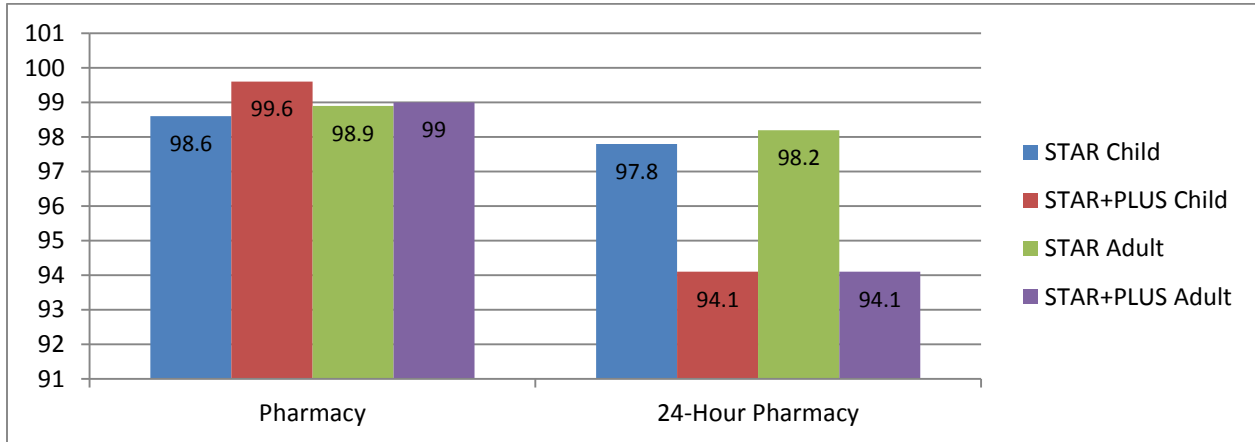
Figure 13: SFQ3 STAR+PLUS Program – Percent of Adults with Access to One Provider



The charts show that, as a whole, the STAR and STAR+PLUS programs exceeded the State’s 90 percent benchmarks for almost all provider types, generally providing 94 or more percent of members with access to each provider type. Program averages were lower than the 90 percent benchmark for outpatient behavioral health hospitals.

Attachments J and K also include the health plans’ GeoMapping results for pharmacy providers, and again are compatible with the SDS analysis. As demonstrated in the following chart, the plans’ data shows that, as a whole, STAR and STAR+PLUS plans exceeded the 90 percent benchmark for access to one network pharmacy within 15 miles. The plans’ self-reported data also included the number of members who had access to a 24-hour pharmacy within 75 miles, and the program results were again favorable.

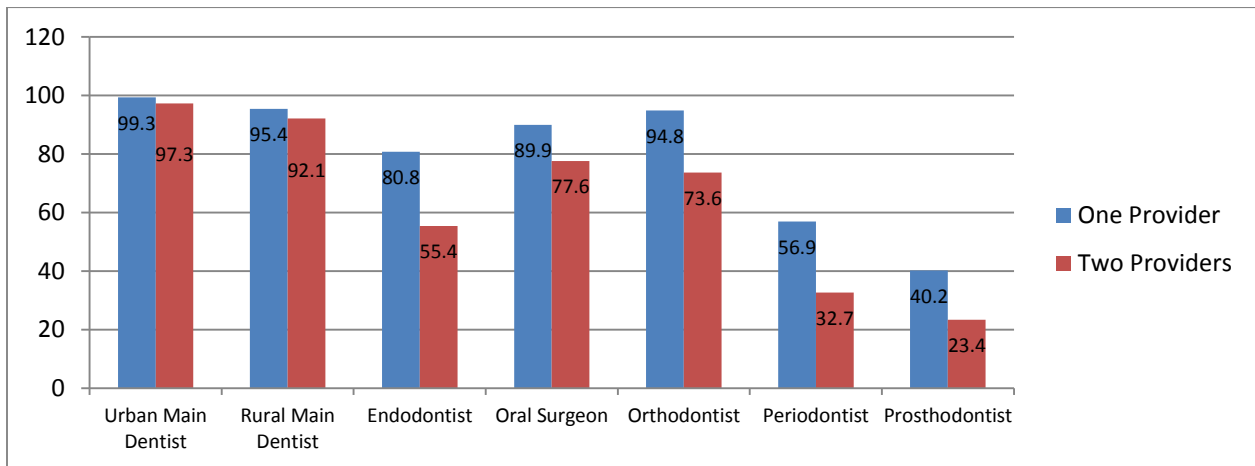
Figure 14: SFQ3 STAR and STAR+PLUS Program – Percent of Children and Adults with Access to a Pharmacy



For all areas where the STAR and STAR+PLUS plans did not meet performance benchmarks, the State will monitor the plans for improved performance, and impose contractual remedies as appropriate.

In the Children’s Medicaid Dental Program, results were somewhat mixed. Attachment L includes the dental plans’ self-reported GeoMapping results for SFQ3. This data is generally consistent with SDS’ findings, and shows that members normally had access to two main dentists within the required distances, but sometimes had to travel farther to specialists. The following chart tracks program averages for access to one and two providers, based on the dental plans’ self-reported data.

Figure 15: SFQ3 Children’s Medicaid Dental Services – Percent of Members with Access to One and Two Providers



The dental plans’ data show that most members had access to a main dentist within the required mileage standards. The dental plans reported that, as a whole, 99.3 percent of members in urban counties had access to one main dentist within 30 miles, and 97.3 percent had access to two. In rural counties, 95.4 percent of members had access to one main dentist within 75 miles, and 92.1 to two. Although the dental plans generally were able to provide members with access to one

oral surgeon and orthodontist in within the prescribed distances, they had difficulty meeting the State's access standards for other specialty types.

Dental plans faced challenges meeting the State's standards for access to two endodontists, oral surgeons, orthodontists, periodontists, and prosthodontists. Such difficulty most commonly arose in rural regions of the State, such as West Texas, where specialists have historically been less geographically concentrated than in urban areas. Although provider enrollment challenges are not unique to managed care, the State will continue to monitor the dental plans for improved performance in these regions. In addition, the State will conduct further analysis to determine whether the current benchmarks are appropriate for all categories of dental specialists and all parts of the state.

6. Service Utilization

This part addresses STC 24(e)'s annual reporting requirements regarding service utilization by the Demonstration population. Supporting data is located in Attachments M through O.

To determine the types of healthcare service most frequently accessed from SFQ2-SFQ4, the State applied Berenson-Eggers Type of Service (BETOS) codes to plan encounter data, and calculated the top five service services per BETOS code. Results for the STAR and STAR+PLUS populations are included in Attachment M, and show members in these programs most commonly accessed the following categories of acute care services: evaluation and management, tests, and "other" services. The most frequently used acute care services were: established office visits, lab tests, immunizations/vaccinations, and emergency room visits. The most frequently used long-term services and supports for STAR+PLUS members were: attendant care, clinical visits, day care services, private duty nursing, and off-hour office visits.

The State used a different process to track STAR and STAR+PLUS pharmacy utilization during SFQ2-SFQ4. Using plan encounter data, the State tracked the total number of prescriptions filled, the percentage of generic versus brand-name drugs, and the average number of prescriptions filled each month per member. Attachment N includes the State's analysis, and demonstrates that in the first six months following the March 1, 2012 pharmacy carve-in, the number of prescriptions filled in STAR exceeded 9.2 million, and 4.3 million in STAR+PLUS. During this time, generic drug utilization accounted for approximately 70 percent of STAR and 73 percent of STAR+PLUS prescriptions. On average, STAR+PLUS members filled almost three times as many prescriptions per month as STAR members, approximately 1.81 prescriptions per month in STAR+PLUS versus .62 prescriptions per month in STAR.

To determine the types of dental services most commonly accessed in Children's Medicaid Dental Services, the State applied the American Dental Association's grouping categories to dental plan encounters, and calculated the top five services per category. As shown in Attachment O, in SFQ3 to SFQ4 the most common categories of services used were: preventative services, radiographs/diagnostic imaging, clinical oral evaluations, and resin-based composite restorations. Members most frequently used the following services: sealants, periodic oral evaluations for established patients, intraoral imaging, and resin-based composites for two posterior surfaces.

7. Out-of-Network Utilization

This part addresses members' use of out-of-network providers, which is a quarterly reporting requirement in STCs 39(a) and 65. Supporting data is found in Attachment B.

As required by Texas law,³ the State has adopted the following performance standards for out-of-network usage.⁴ Services provided by out-of-network facilities and providers should not exceed the following amounts in each service area:

- 15 percent of inpatient hospital admissions;
- 20 percent of emergency room visits; and
- 20 percent of all other services.

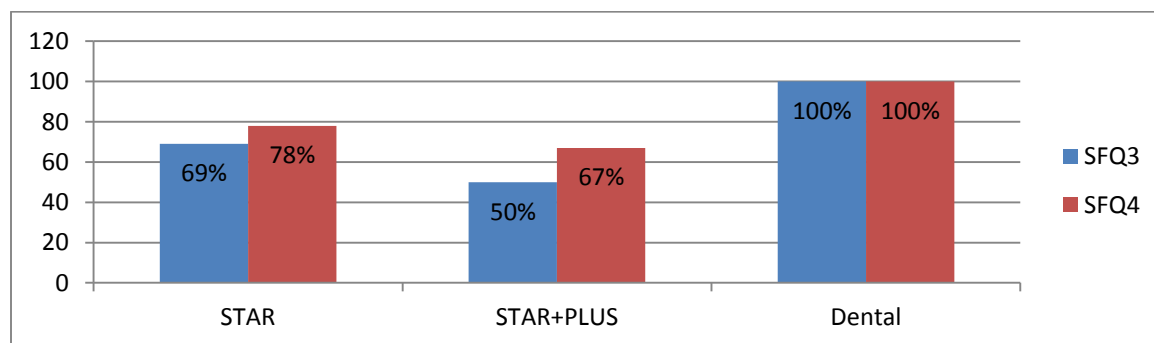
Plans can request “special consideration” if they exceed these standards but can demonstrate good faith efforts to contract with out-of-network providers. If the State grants the special consideration, it removes providers who refuse to contract with the plan from compliance calculations.

Healthcare plans showed moderate improvement in non-network utilization in SFQ4; however, some exceeded the benchmarks, even after receiving special consideration. As a whole, STAR plans complied with all benchmarks in 35 of 45 reported service areas, and STAR+PLUS in 16 of 24.

In Children's Medicaid Dental Services, the 20 percent standard for “other services” applies to out-of-network dental services. All three dental plans reported out-of-network utilization well below the 20 percent threshold in SFQ4.

The following chart demonstrates total program compliance in SFQ4 compared to SFQ3, based on the number of reported service areas where plans met all benchmark standards.

Figure 16: SFQ4 Compliance Percentages for Out-of-Network Utilization



Noncompliant plans cite a number of contributing factors for out-of-network utilization. Several plans reported difficulty contracting for inpatient and emergency hospital services, especially in the Bexar, Dallas, and Harris service areas. Others reported excess out-of-network utilization due to the managed care contracts' requirements for continuity of care, which are designed to

³ Tex. Gov.'t Code §533.005(a)(11).

⁴ 1 T.A.C. §353.4(e)(2).

ensure that care is not disrupted for newly-enrolled members. The contracts allow pregnant members past the 24th week of gestation to remain with their obstetricians through postpartum care, and terminally ill members to see their providers for up to nine months.

HHSC will continue to monitor out-of-network utilization to determine if trends continue to improve over time, and will require corrective action or other remedies if appropriate.

D. Anticipated Changes in Populations or Benefits

This section addresses the quarterly reporting requirements in STC 65, regarding anticipated changes in populations or benefits.

As discussed during the monthly monitoring meetings with the CMS, the State plans to expand the STAR+PLUS managed care program into the Medicaid Rural Service Area (MRSA). HHSC placed a draft Request for Proposals (RFP) for this expansion on its website on October 11, 2012 for public comment. After reviewing stakeholder input, HHSC plans to post the final RFP in December 2012. Selected plans will complete readiness reviews, then begin serving clients on September 1, 2014.

The State will submit a waiver amendment for the STAR+PLUS MRSA prior to implementation, and will keep CMS informed of any new developments as they arise. The State is not planning other amendments at this time.

E. Enrollment Counts for Quarter

This section includes quarterly enrollment counts, as required by STCs 52 and 65. Due to the time it takes for State data to complete, unique client counts per quarter are reported on a two quarter lag. The following table includes enrollment counts for the 2012 Federal Fiscal Quarter 2 (Q2), which includes the January 1, 2012 – March 31, 2012 timeframe. Enrollment counts are based on persons, and not member months.

Figure 17: Enrollment Counts for Q2

Demonstration Populations	Total No.
Adults	293,592
Children	2,758,568
AMR	295,984
Disabled	424,445

III. Outreach/Innovative Activities to Assure Access

This section addresses STC 65’s quarterly requirements regarding outreach and other initiatives to ensure access to care. It also addresses the quarterly reporting requirement found in STC 40(c), regarding dental stakeholder meetings. Supporting data is available in Attachment P.

A. Enrollment Broker and Plan Activities

The State's enrollment broker, MAXIMUS, performs various outreach efforts to inform potential eligibles about their medical and dental enrollment options. During the Q4 Demonstration period (July-September 2012), MAXIMUS sent 263,874 enrollment mailings to STAR and STAR+PLUS eligibles, and 196,172 enrollment mailings for Children's Medicaid Dental Services. MAXIMUS field staff completed 16,409 home visit attempts for these programs, and 58,946 phone calls attempts. Additionally, MAXIMUS completed 4,284 field events, which include enrollment events, community contacts, presentations, and health fairs.

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 out-of-network referrals;
- Texas Health Steps benefits; and
- the State's Medical Transportation Program.

To promote access to care, health and dental plans must update their online provider directories at least once a quarter. Plans also must mail member handbooks to new members no later than five days after receiving the State's enrollment file, and to all members at least annually and upon request. The handbooks must describe how to access primary and specialty care. Through the member handbooks and other educational initiatives, plans must instruct members on topics such as:

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

B. Dental Stakeholder Meeting

The State held one quarterly dental stakeholders meeting in Q4. The meeting took place on July 27, 2012 at the Health and Human Services Commission's main office in Austin, Texas. The meeting was open to the public, and participants also had the opportunity to participate via webinar.

Representatives from the Health and Human Services Commission, the Department of State Health Services, and the three dental plans attended the meeting, as well as the Texas Dental Association, the Texas Academy of General Dentistry, the Texas State Board of Dental Examiners, the American Orthodontic Society, the Office of Inspector General (OIG), and various news outlets. Approximately 100 dentists and orthodontists from various parts of Texas attended the meeting in Austin, not including webinar participants.

The State posted the agenda online prior to the meeting, and set up a mailbox at DentalStakeholderMeeting@hsc.state.tx.us to capture stakeholder questions prior to the

meeting. During the meeting, the State presented topics and responded to questions on various topics, including: the dental plans' fee schedules; provider payment appeals; perceived marketing violations; orthodontia transfer cases; and electronic claims submission.

The agenda and presentation are available at

<http://www.hhsc.state.tx.us/news/meetings/past/2012/072712-Dental-Stakeholders-Meeting.shtml>.

IV. Collection and Verification of Encounter Data and Enrollment Data

This section addresses the quarterly reporting requirements of STC 65, regarding significant issues, activities, or findings related to the collection and verification of encounter 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. During the Q4 Demonstration period, the State did not identify any significant issues regarding the collection or verification of enrollment data.

As previously reported, the State identified an issue with encounter data that affected the current and prior Demonstration quarters. HHSC identified a number of mapping issues related to the Health Insurance Portability and Accountability Act 5010 837 encounter implementation by its administrative services contractor, ACS State Healthcare, L.L.C (d.b.a. Texas Medicaid and Healthcare Partnership). ACS corrected these mapping issues in August, 2012, and the State has resumed the plan encounter financial reconciliation process for the SFY 2012. At this time, the State has contacted each plan that did not achieve the financial reconciliation threshold, and advised them of the necessary steps to achieve certification.

V. Operational/Policy/Systems/Fiscal Developments/Issues

This section addresses the quarterly reporting requirements found in STC 65, and provides an update on operational issues identified in the prior quarter's report. It also addresses pending lawsuits that may potentially impact the Demonstration, and new issues identified during the reported quarter.

A. Update on Operational Issues Identified in the Prior Quarter

The State identified two operational issues in its previous Section 1115 Quarterly Report – access to orthodontia services in the Children's Medicaid Dental Services program, and Molina Healthcare of Texas' STAR+PLUS rate reductions.

1. Access to Orthodontia in Children's Medicaid Dental Services

The HHSC Office of Inspector General (OIG) has placed several hundred orthodontic providers on payment hold, based in large part on issues identified prior to the implementation of dental managed care. As a result, a number of providers ended their Texas Medicaid provider agreements and discontinued orthodontic treatments.

The State continues to coordinate with the dental plans, OIG, and the Texas State Dental Board to ensure children are transitioned to new orthodontia providers when necessary. Dental plans have reported success locating providers willing to accept transfer clients and conduct complete assessments to determine each child's needs on a case-by-case basis.

2. *Molina Rate Decreases*

As addressed in the State's previous quarterly report, Molina implemented rate reductions for STAR+PLUS durable medical equipment, personal attendant services, day activity health services, and home health providers. Through monitoring efforts, the State has determined that the reductions did not have a significant impact on member access to care. In its last quarterly report, the State identified four providers who notified Molina of their intent to terminate their network agreements based on the rate reduction, impacting 14 members. Since that time, Molina was able to reach agreement with some of these providers, resulting in only two provider-initiated terminations, and seven rather than fourteen, impacted members.

As described in Section II(C), Molina's provider recruitment efforts were largely successful in SFQ4, resulting in considerable network gains in almost all of its STAR+PLUS service areas. Of note, however, is the number of members who have opted out of Molina's STAR+PLUS product in the Hidalgo service area. From SFQ3 and SFQ4, Molina's Hidalgo membership dropped by 9,721 members, representing a 30.53 percent decrease. The State attributes this shift, in large part, to the efforts of advocacy groups opposed to the provider rate decreases.

The State will continue to monitor this situation, including its impact on member enrollment.

B. Litigation Update

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

Southwest Pharmacy Solutions d/b/a American Pharmacies v. THHSC and Suehs. Filed on August 26, 2011, in state district court in Travis County. Currently on appeal to the Third Court of Appeals, Austin. Pharmacy providers challenged HHSC's 1115 waiver application, complaining that the application was a rule and that HHSC failed to provide the interested public with adequate notice and opportunity for comment. On August 29, 2011, State District Judge Rhonda Hurley denied Plaintiffs' request for a temporary restraining order (TRO) to stop implementation of the waiver. On November 3, 2011, State District Judge Stephen Yelenosky granted HHSC's motion to dismiss the lawsuit. Plaintiffs appealed. The Third Court of Appeals (Austin) heard oral argument on September 12, 2012.

Pharmacy Buying Association, Inc. d/b/a PBA Health and Texas TrueCare v. HHSC and Suehs. Filed on February 17, 2012, in federal district court in Austin. Pharmacies complained that THHSC improperly delegated to Medicaid managed care organizations and their Pharmacy Benefits Managers (PBMs) the responsibility to set pharmacy reimbursement rates. They claimed that low rates will cause pharmacies to withdraw from the Medicaid program and result in a lack of access to pharmacy services for Medicaid clients. The pharmacies asked the federal court to restrain HHSC from implementing the carve-in of pharmacy services to Medicaid managed care. Following a hearing on February 24, U.S. District Judge Sam Sparks denied Plaintiffs' request for a TRO based, in part, on a finding that Plaintiffs had not shown an

imminent threat of irreparable injury. Judge Sparks denied Defendant's initial motion to dismiss. On April 6, plaintiffs amended their lawsuit to non-suit HHSC, while retaining HHSC Executive Commissioner Thomas Suehs as a defendant (since replaced by new HHSC Executive Commissioner Kyle L. Janek, M.D.), and adding HHS Secretary Kathleen Sebelius as a defendant. Plaintiff sought relief under the federal Administrative Procedure Act. The Office of the Attorney General (OAG) filed a second motion to dismiss, and Secretary Sebelius filed a general denial. On October 29, 2012, U.S. District Judge Sparks granted a motion to dismiss claims against Janek without prejudice, while allowing Plaintiffs 30 days to file an amended complaint.

Southwest Pharmacy Solutions d/b/a American Pharmacies v. Suehs. Filed February 14, 2012, in federal district court in Austin. Another group of pharmacies complained that HHSC improperly delegated to managed care organizations and PBMs the responsibility to set pharmacy reimbursement rates and claim that low rates will eventually affect access to pharmacy services. They asked the federal court to restrain HHSC from implementing the carve-in of pharmacy services to Medicaid managed care. On February 29, Judge Sparks denied the Plaintiffs' request for a TRO, again based on Plaintiffs failure to demonstrate an imminent and irreparable injury. On June 1, 2012, Judge Sparks granted the OAG's motion to dismiss the lawsuit. No appeal was taken. Note however that the dismissal was without prejudice; if plaintiffs could show that rates were too low, they could refile their lawsuit.

Southwest Pharmacy Solutions d/b/a American Pharmacies v. HHSC and Suehs. Filed on February 17, 2012, in state district court in Travis County. Pharmacy providers claimed that HHSC is obligated under state law to regulate pharmacy reimbursement, including dispensing fees, and that HHSC failed in this obligation when it allowed PBMs to determine reimbursement for pharmacies participating in Medicaid managed care. They also complained that HHSC failed to modify the administrative rules related to the carve-in of pharmacy benefits to reduce their impact on small business pharmacies. The providers asked the court to restrain HHSC from implementing the carve-in and to declare the reimbursement rates paid by PBMs invalid. On March 1, 2012, State District Judge John Dietz denied Plaintiffs' request for a TRO based, in part, on Plaintiffs failure to demonstrate harm. He deferred a ruling on Defendants' motion to dismiss. On April 24, Judge Dietz granted the State's plea to the jurisdiction and dismissed the lawsuit with prejudice. The plaintiffs appealed to the Third Court of Appeals. Briefs were filed in August (by Appellant) and September (by the State/Appellee). The case remains pending.

Dr. Essa Kawaja, DDS; Summit Dental Center, Dental Smiles; Dr. Anila Shah, DDS, PA. v. HHSC, Suehs, Delta Dental, Dentaquest USA, and Managed Care of North America. Filed on February 28, 2012, in state district court in Travis County. Dental providers complained of the default enrollment procedures for Medicaid managed care clients that do not choose a provider. They asked the court to restrain HHSC and the Medicaid dental maintenance organizations from implementing the default enrollment procedures and to declare those procedures illegal. HHSC voluntarily delayed the dental home requirement until May 31, 2012, to allow clients more time to notify their dental plan of their preferred dentist without any disruption in service. Plaintiffs withdrew their request for a TRO following HHSC's action, but the lawsuit remains pending. OAG has filed a general denial and a plea to the jurisdiction.

C. New Issues

1. *Delta Dental Contract Close-Out*

The State and Delta Dental Insurance Company have reached a mutual agreement to end the parties' contract for CHIP and Children's Medicaid Dental Services. As addressed in the State's previous two quarterly reports, problems at the implementation of the Medicaid dental program led HHSC to suspend new enrollments into the plan. While the State eventually lifted this suspension, the parties ultimately determined that ending the contract was the best course of action. The State notified the CMS of this decision on September 4, 2012.

Delta Dental will continue to provide services to Medicaid and CHIP clients through November 30, 2012. Beginning December 1, 2012, these clients will receive services through DentaQuest or MCNA.

The State has been working with its administrative services contractors and all three dental plans to ensure a smooth transition. The State began posting information concerning the transition on its website and the Texas Medicaid Healthcare Partnership website on September 13, 2012.⁵ The State also trained its staff to respond to inquiries regarding this change, and developed talking points for State helpline, Ombudsman, and 2-1-1 staff (see Attachment Q).

In September 2012, MAXIMUS began removing Delta Dental from all client materials, such as comparison charts, letters, and enrollment forms. Clients enrolling on or after November 1, 2012 will no longer be able to select Delta Dental.

Attachment R is the template notification letter that MAXIMUS sent Delta Dental's clients in November, following the managed care enrollment cut-off date. The letter informed members of their newly-assigned plans, but let them know they could change plans by calling a toll-free number.

The State will continue to communicate with the CMS about any developments that arise on or after the December 1, 2012 transition.

2. *United Healthcare Community Plan's Unattended Complaints*

The State recently discovered that United Healthcare Community Plan likely underreported the number of STAR and STAR+PLUS provider complaints and member appeals for SFQ3 and SFQ4. The problem arose after United's March 1, 2012 systems conversion. On October 24, 2012, United notified the State of a systems workflow issue regarding provider inquiries and appeals, which may have had a downstream effect on member appeals. After the system conversion, this information was sent to a "bucket" within the system that United staff was not aware of and therefore did not review. United is still assessing the impact of this error, but estimates that there were 5,000 backlogged items in this system bucket. United is triaging each item to ensure it is tracked, routed, processed, and reported correctly.

⁵ See HHSC's website at <http://www.hhsc.state.tx.us/medicaid/Children-Medicaid-Dental-Services.shtml>, and the TMHP website at http://www.tmhp.com/Pages/Medicaid/Medicaid_Managed_Care.aspx under "Related News Items."

It is likely that this issue will impact the number of provider and member complaints that United reported for SFQ3 and SFQ4. Once the matter is resolved, United will submit revised reports for these quarters, and the State will provide updated information to the CMS in a future quarterly report. In the interim, the State has placed United on corrective action and is requiring the plan to submit biweekly reports regarding its progress on the backlog. The State will conduct an onsite review in November, and will monitor the situation closely through resolution. The State will impose contractual remedies, including monetary damages, as appropriate.

3. Other Issues

Other than the items identified above, there were no fiscal, litigation, or systems issues, and no legislative activity in Q4 reporting period. 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

Please refer to Section V(C) and other of this report for the State's action plans for addressing new issues identified during the reporting period. HHSC will continue to monitor these issues and will require corrective action or impose other contractual remedies as appropriate.

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 Q4. The State does not anticipate any such activity in the near future that affects healthcare delivery.

VII. Financial/Budget Neutrality Development/Issues

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

There were no significant development/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality report for Q4.

VIII. Member Month Reporting

The table below (Figure 18) addresses the quarterly reporting requirements in STC 52, regarding eligible member month participants.

Figure 18: Eligible Member Month Participants

	STAR Program		STAR+PLUS Program		PCCM I/P Program
	D&B	TANF Related	D&B	Aged & MR	PCCM I/P
Jul-12	-11	2,141,230	179,548	223,336	-43
Aug-12	-7	2,117,397	178,782	220,910	-149
Sep-12	-3	2,107,134	180,291	222,826	-32

The primary care case management numbers are being created due to the 24 month (look back) adjustment period following the end of the program

The tables below (Figures 19 and 20) address the quarterly reporting requirements in STC 65, regarding member months.

Figure 19: Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (July 2012)	Month 2 (August 2012)	Month 3 (September 2012)	Total for Quarter Ending 09/12
Adults	251,137	252,795	253,979	757,911
Children	2,573,914	2,579,141	2,565,526	7,718,580
AMR	286,218	285,607	284,885	856,710
Disabled	415,441	415,425	418,492	1,249,358

Figure 20: Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (July 2012)	Month 2 (August 2012)	Month 3 (September 2012)	Total for Quarter Ending 09/12
AMR in MRSA	77,245	76,920	77,301	231,466
Foster Care	34,271	34,088	34,125	102,483
Medically Needy	286	282	288	857
Qualified Aliens	18,101	18,116	17,852	54,068

IX. Consumer Issues

This section addresses the quarterly reporting requirements from STCs 39(a) and 65, including complaints received in SFQ4; trends discovered and steps taken to resolve complaints and prevent future occurrences; and calls to the HHSC help desk. Attachments S through U include supporting data for this section.

A. Customer Service Reporting

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.

1. Call Volumes and Hotline Performance

STAR and STAR+PLUS plans report consolidated hotline reports. The reports include all of a plan's STAR, STAR+PLUS and CHIP programs, and include combined data for all contracted service areas. Conversely, dental plans do not consolidate data for the CHIP and Children's Medicaid Dental Services programs.

As described in the State's previous 1115 quarterly report, call volumes rose significantly in SFQ3 following the March 2012 expansions. In SFQ4, call volumes began to stabilize in all three Demonstration programs.

In SFQ4, there was a considerable drop in the number of calls placed to healthcare and dental plans, as seen in Attachment S. Total calls to the healthcare plans' member, provider, and behavioral health crisis hotlines dropped by 19.22, 1.23, and 25.12 percent, respectively. Total calls to the dental plans' member and provider hotlines also dropped significantly in SFQ4, down by 28.33 and 18.63 percent.

As call volumes dropped in SFQ4, plan performance improved. HHSC's managed care contracts establish the following benchmarks for hotline performance:

- 99 percent of all calls must be answered by the 4th ring;
- ≤ 1 percent busy signal rate for all calls;
- 80 percent of all calls must be answered by a live person within 30 seconds;
- ≤ 7 percent call abandonment rate; and
- ≤ 2 minute average hold time.

As indicated in Attachment S, most STAR and STAR+PLUS plans effectively handled calls and met or exceeded all of these performance standards for member, behavioral health, and provider hotlines in SFQ4. On one measure, two healthcare plans fell short. Health Care Services Corporation and United missed the 99 percent standard for member hotline calls answered by the fourth ring, with compliance rates of 95.56 and 98.61 percent, respectively. Overall compliance was up from SFQ3, when five healthcare plans fell short on one or more hotline performance measures.

Hotline performance also improved significantly for Children's Medicaid Dental Services. In SFQ3, two dental plans experienced difficulty meeting one or more hotline standards. In SFQ4, all three dental plans met or exceeded all performance standards.

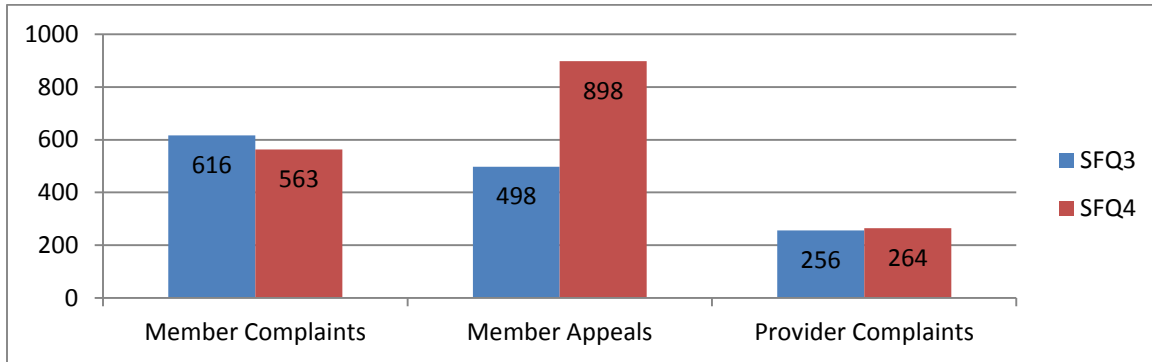
2. Volume and Resolution of Complaints and Appeals Received by Plans

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 set a 98 percent compliance benchmark. With some exceptions, plans successfully met this benchmark in SFQ4.

a. STAR and STAR+PLUS

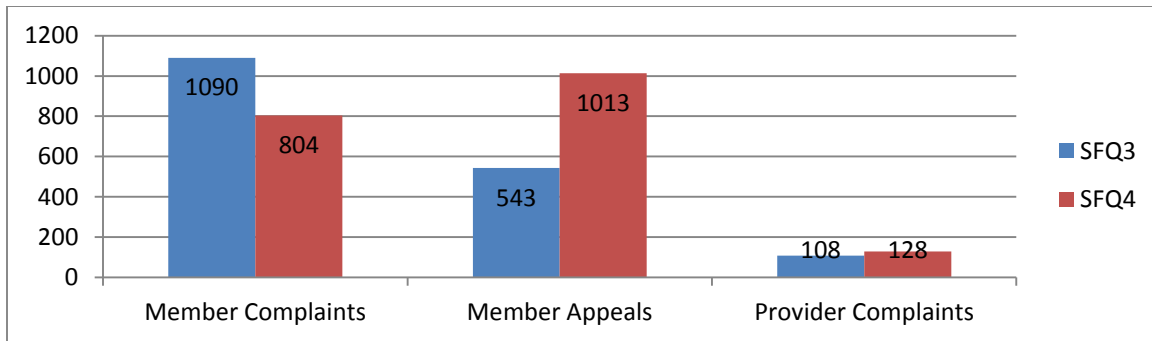
As seen in Attachment T, the number of complaints and appeals to STAR and STAR+PLUS plans generally rose in SFQ4. STAR plans reported a total of 563 member complaints, 898 member appeals, and 264 provider complaints. As demonstrated in the following table, this represents a drop in member complaints, but a rise in member appeals and provider complaints.

Figure 21: Complaints and Appeals Received by STAR Plans



STAR+PLUS plans reported similar results in SFQ4, with an overall drop in member complaints, but a rise in member appeals and provider complaints. STAR+PLUS plans reported 804 member complaints, 1013 member appeals, and 128 provider complaints in SFQ4.

Figure 22: Complaints and Appeals Received by STAR+PLUS Plans



In both programs, the most common member complaints to plans involved: dissatisfaction with the quality of care provided by a treating physician or other provider; difficulties with accessibility or availability of services; and claims issues. Member appeals most commonly involved the denial or limitation of a benefit, or an untimely response to an authorization requests. Providers generally complained about plan administration, and claims processing, billing, or denials.

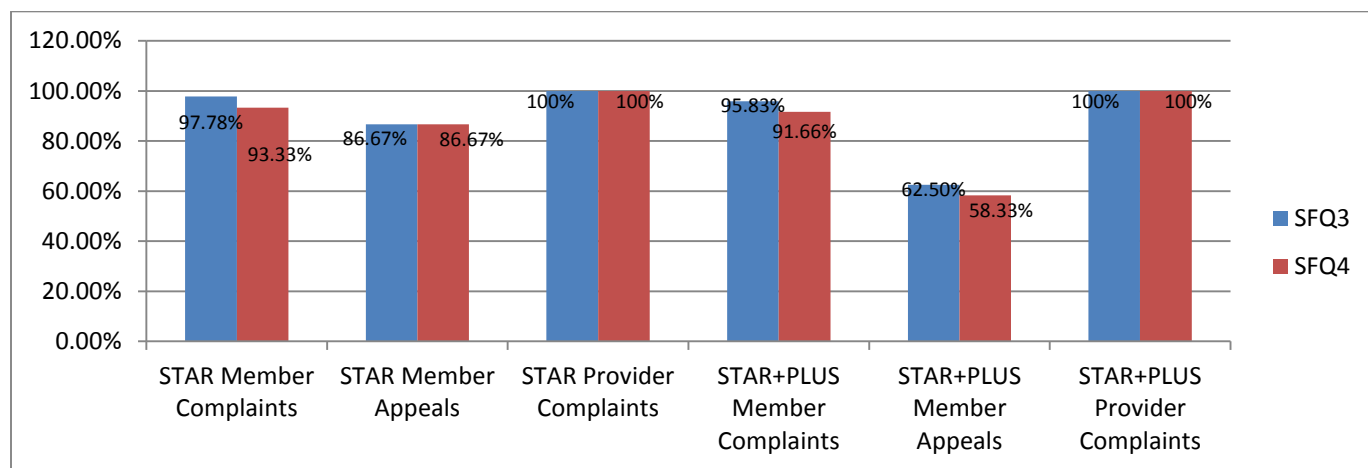
In SFQ4, a large percent of member appeals and provider complaints occurred in the expansion service areas. The four newest STAR service areas (Hidalgo, MRSA Central, MRSA Northeast,

and MRSA West) generated 69.8 percent of all member appeals and 55.3 percent of all provider complaints. Likewise, the three newest STAR+PLUS service areas (Hidalgo, El Paso, and Lubbock) had 34.6 percent of all member appeals and 31.3 percent of all provider complaints. The state anticipates that this trend will stabilize over time, as members and providers become more familiar with managed care and the plans' processes and procedures.

In SFQ4, most plans met the State's 98 percent benchmarks for resolving complaints and appeals within 30 days; however, total compliance rates were down for some measurements. All STAR and STAR+PLUS plans met the 98 percent benchmark for timely resolution of provider complaints for the second consecutive quarter. Compliance rates were also high for timely resolution of member complaints, where STAR plans met the benchmark in 42 of 45 reported service areas, and STAR+PLUS plans in 22 of 24 service areas. Compliance rates were lower for timely resolution of member appeals, where STAR plans met the benchmark in 39 of 45 reported service areas, and STAR+PLUS plans in 14 of 24 service areas.

The following chart shows the percentage of plans that met the 98 percent benchmarks in SFQ3 and SFQ4.

Figure 23: Compliance with Complaints and Appeals Resolution Benchmarks



In some cases, plans that did not meet the benchmark had relatively low numbers of complaints or appeals, resulting in lower compliance percentages than plans with higher volumes of complaints and appeals. For example, in the Central MRSA, Amerigroup received only nine member appeals, and resolved one after the 30 day deadline. Although the plan missed the deadline on only one appeal, its compliance rate was under the benchmark at 88.89 percent.

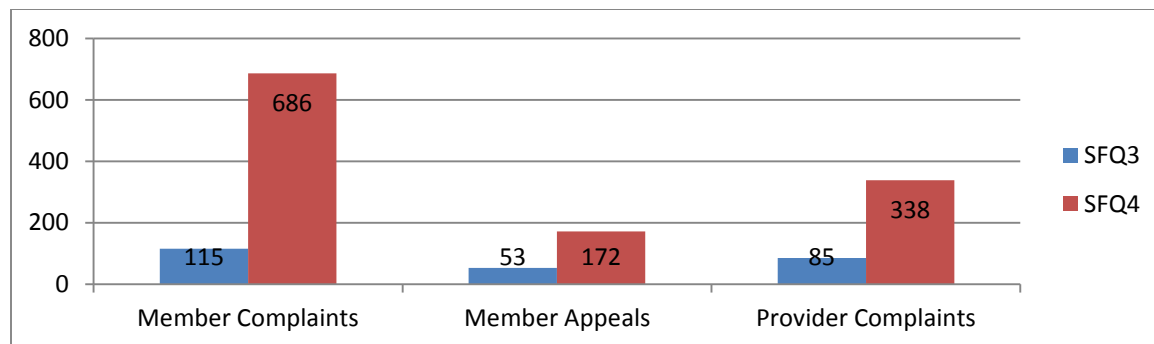
The State's Health Plan Management staff is investigating other reasons for noncompliance, and will require corrective action or financial remedies as appropriate. The State will also monitor compliance percentages for performance improvements.

b. Children's Medicaid Dental Services

As demonstrated in the following table, dental plans reported notable increases in complaints and appeals in SFQ4. Dental plans reported a total of 686 member complaints, 172 member appeals, and 338 provider complaints. The State anticipated some of this increase, as dental utilization

tends to increase in the summer months when parents normally schedule more dental check-ups. It is not uncommon for complaints and appeals to also rise with this increased utilization.

Figure 24: Complaints and Appeals Received by Dental Plans



The most common member complaints to the dental plans involved access to or availability of services, and dissatisfaction with the quality of care provided by a treating dental provider. Member appeals most commonly related to the dental plan’s utilization review or management, such as the denial of prior authorization requests. Providers generally complained about plan administration; denials or limitations of benefits; and claims processing, billing, and denials.

Despite increases in complaints and appeals in SFQ4, the dental plans were generally able to resolve these matters efficiently, and met or exceeded the contract’s 98 percent benchmarks for timely resolution. The exception was MCNA, which resolved one member appeal after 30 days, resulting in 97.70 percent compliance -- just below the 98 percent benchmark. MCNA also resolved three provider complaints after the 30 day deadline, resulting in 93.60 percent compliance.

3. *Complaints Received by the State*

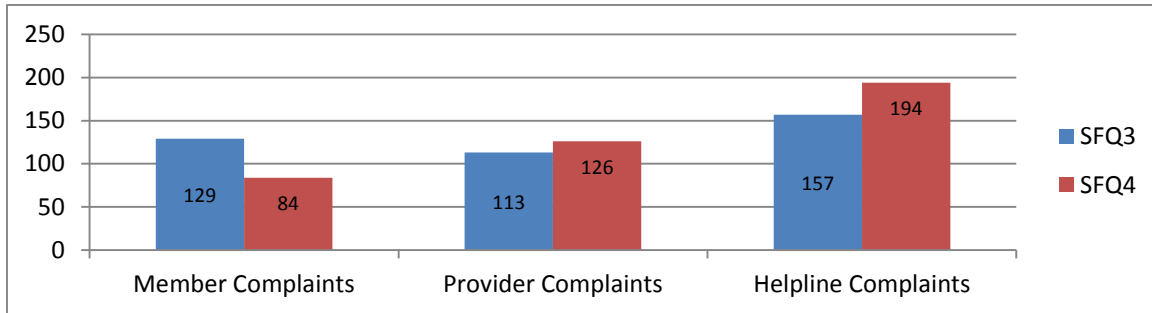
In addition to monitoring complaints received by plans, the State also tracks the number and types of complaints received by Health Plan Management staff and through the State’s helpline. After investigating each complaint, State staff determines whether or not it is justified. Attachment U includes information concerning complaints received by the State in SFQ4.

a. STAR and STAR+PLUS

In both STAR and STAR+PLUS, the number of complaints to the State generally rose in SFQ4, with the exception of STAR member complaints. These increases were within normal seasonal ranges, as complaints tend to rise in the summer months when parents often schedule preventative care for their children.

For STAR, the state received 84 member, 126 provider, and 194 helpline complaints in SFQ4. Plans with the highest number of enrollees, Superior and Amerigroup, received the highest number of complaints. Two expansion service areas had the highest numbers of complaints – the Northeast and Central MRSAs. The following table shows the total number of complaints the State received regarding STAR plans in SFQ4, compared to the total for SFQ3.

Figure 25: Complaints to the State Regarding STAR

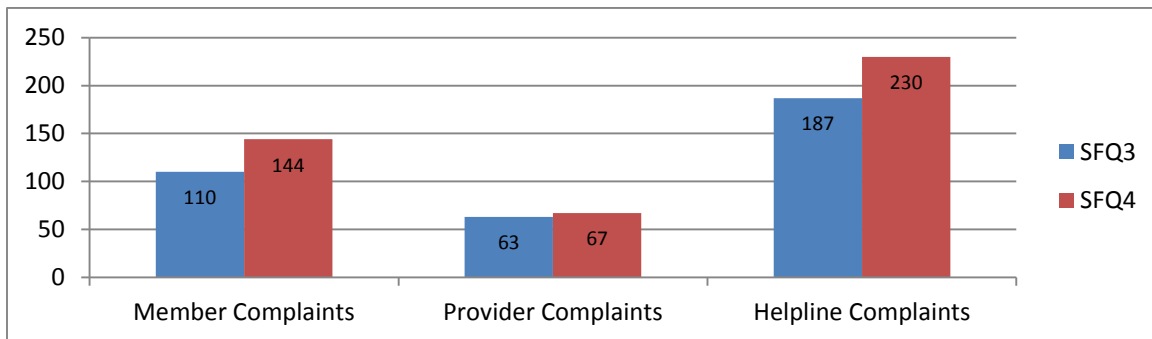


The State determined that a large part of STAR complaints were not justified: 37 member (44.05 percent), 62 provider (49.21 percent), and 169 helpline (87.11 percent).

Complaints regarding the STAR+PLUS plans were also up in SFQ4. Superior and Molina, two of the largest plans, generated the highest number of complaints. The Dallas and Hidalgo service areas generated the largest number of complaints.

The State received the following number of complaints regarding STAR+PLUS in SFQ4: 144 member, 67 provider, and 230 helpline. The following table compares SFQ4 results to SFQ3.

Figure 26: Complaints to the State Regarding STAR+PLUS



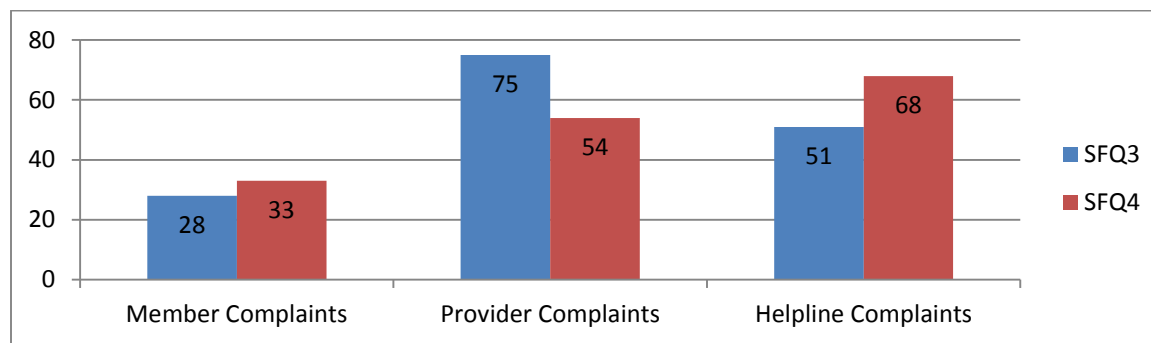
As with STAR, State staff determined that a large portion of STAR+PLUS complaints were not justified. The total numbers of unjustified complaints were: 78 member (54.17 percent), 22 provider (32.84 percent), and 189 helpline (82.17 percent).

For both STAR and STAR+PLUS, justified complaints most commonly related to access to care and specialty providers; claims and billing issues; prescription denials, and delays in receiving referrals or prior authorizations. Justified provider complaints most commonly involved delays in claims handling or recoupment; claims denials; and denial or delay of payment; and prior authorizations. Finally, justified complaints to the helpline were normally about access to specialty care; continuity of treatment; prescription eligibility or prior authorizations; delays in receiving prior authorizations or referrals; PCP selection or turnover; and for STAR+PLUS, access to long-term care services.

b. Children's Medicaid Dental Services

In SFQ4, HHSC received 33 member, 54 provider, and 68 helpline complaints regarding the dental plans. Complaints were spread fairly consistently across the dental plans, with DentaQuest receiving slightly more complaints than the other two plans. The following table depicts the total number of complaints the State received in SFQ4, compared to the prior quarter.

Figure 27: Complaints to the State Regarding Children's Medicaid Dental Services



State staff determined that a large number of the complaints received in SFQ4 were not, in fact, justified. The total number of unjustified complaints was: 19 member (57.58 percent), 22 provider (90.74 percent), and 52 helpline complaints (88.14 percent). Justified member complaints most commonly involved access to network providers and orthodontia services. Justified provider complaints most commonly occurred due to delays in claims handling; claims denials; and denial or delay of payment. Finally, justified complaints to the helpline usually involved continuity of treatment; delays in receiving prior authorizations or referrals; and prior authorization denials.

X. Quality Assurance/Monitoring Activity

This part addresses the quarterly reporting requirements in STC 65, regarding the State's quality assurance and monitoring activities.

The State did not receive any final quality monitoring reports from its external quality review organization during Q4 reporting period.

HHSC will aggressively monitor all STAR, and STAR+PLUS, and Children's Medicaid Dental Services deficiencies identified in the Managed care quarterly reports for SFQ4, as well as member and provider complaints filed directly with the State. Where appropriate, it will require plans to take corrective action and assess contractual remedies, including liquidated damages. As required by state law, HHSC will publish information regarding any such assessments on its website at: <http://www.hhsc.state.tx.us/medicaid/ContractorSanctions/index.html>.

XI. Demonstration Evaluation -- STC 65 Quarterly Reporting Requirement

The following is a summary of the significant evaluation activities undertaken from July 1, 2012, through September 30, 2012. Evaluation activities undertaken in the last quarter include:

- On September 17, 2012 HHSC received comments from CMS on the evaluation plan submitted on July 20, 2012.

- The primary evaluation activity undertaken in the last quarter was to revise the evaluation plan based on the comments provided by CMS. HHSC will resubmit the final evaluation plan on November 16, 2012. This revised evaluation plan includes performance measures for all STCs and provides a framework for the evaluation of the development of the RHP, and the distribution of Delivery System Reform Incentive Payment (DSRIP) and Uncompensated Care (UC) funds.
- HHSC has identified the external evaluator to conduct the evaluation of the development of the RHP, distribution of UC pool funds, and the DSRIP projects undertaken. The external evaluator will also gather stakeholder feedback.
- Once the final evaluation plan is accepted by CMS, HHSC will begin reporting on the performance measures defined in the evaluation plan.

XII. Regional Healthcare Partnership Participating Hospitals -- STC 65 Quarterly Reporting Requirement

In Q4, HHSC worked with waiver stakeholders and CMS to finalize the waiver protocols and develop RHP Plans. An RHP Planning Summit was held on August 7-8, 2012 to discuss RHP Plans, provide updates on HHSC discussions with CMS, and offer technical assistance on the UC Protocol, draft PFM Protocol, draft RHP Planning Protocol, and other planning tools. Nearly 300 invited guests from each of the 20 RHPs and members from the Executive Waiver Committee and Clinical Champions Workgroup were in attendance as well as nearly 300 individuals who viewed the summit over the web. The summit also provided an opportunity for RHP participants to interact, continue their planning efforts, and share ideas.

After CMS approval of the PFM Protocol on August 31, 2012 and the RHP Planning Protocol on September 26, 2012, HHSC hosted four webinars to provide stakeholders with an overview of the final requirements. HHSC also codified the protocol requirements into Texas Administrative Code during Q4. The proposed rules were published on August 24, 2012 for a 30-day public comment period. On September 18, 2012, a public hearing was held to receive additional public comment. Because stakeholders were given many opportunities to provide feedback on the protocols, few public comments were received. The rules were adopted with an effective date of October 31, 2012.

HHSC continues working with waiver stakeholders to submit RHP Plans no later than December 31, 2012. In Q4, HHSC hosted targeted technical assistance sessions at the request of RHPs, developed an RHP Plan Template, Anchor Checklist, and Electronic Workbook to guide RHPs in plan submission, and increased the frequency of Anchor calls from bi-weekly to weekly to address any local questions or concerns promptly. With CMS approval, HHSC extended the timeline for plan submission using a phased approach: submission of the community needs to HHSC and CMS by October 31, 2012 to meet the requirement of STC 45.d.iii; submission of Pass 1 projects to HHSC by November 16, 2012; and submission of a complete plan to HHSC by December 31, 2012.

The Performing Providers and UC participants will be submitted to CMS in the state approved RHP Plans in February 2013. The State expects to report details on the Performing Providers and progress on milestones beginning with the Q2 report for federal fiscal year 2013.

Enclosures/Attachments

Attachment A – Annual Enrollment Summary. The attachment includes annual and quarterly enrollment summaries for the three Waiver programs.

Attachment B – Network Summary. The attachment summarizes STAR and STAR+PLUS network enrollment by managed care organizations, service areas, and provider types.

Attachment C – Pharmacy Network. The attachment summarizes STAR and STAR+PLUS pharmacy network participation.

Attachment D – Provider Network Summary. The attachment summarizes STAR and STAR+PLUS provider networks for SFQ2.

Attachment E – Provider Network Summary. The attachment summarizes STAR and STAR+PLUS provider networks for SFQ3.

Attachment F – SDS STAR GeoMapping. The attachment shows the State’s GeoMapping analysis for STAR plans for SFQ2,.

Attachment G – SDS STAR GeoMapping. The attachment shows the State’s GeoMapping analysis for STAR plans for SFQ3.

Attachment H – SDS STAR+PLUS GeoMapping. The attachment provides results of the State’s GeoMapping analysis for STAR+PLUS plans for SFQ3.

Attachment I – SDS Pharmacy Dental GeoMapping. The attachment includes the State’s GeoMapping analysis for STAR and STAR+PLUS pharmacy access for SFQ3.

Attachment J – SFQ3 STAR GeoMapping Summary. The attachment includes the STAR plans’ self-reported GeoMapping results for SFQ3.

Attachment K – SFQ3 STAR+PLUS GeoMapping Summary. The attachment includes the STAR+PLUS plans’ self-reported GeoMapping results for SFQ3.

Attachment L – SFQ3 Children’s Medicaid Dental Services GeoMapping Summary. The attachment includes the dental plans’ self-reported GeoMapping results for SFQ3.

Attachment M – Annual STAR and STAR+PLUS Service Utilization. The attachment provides the top five service groupings by BETOS code from SFQ2-SFQ4.

Attachment N – Pharmacy Utilization. The attachment includes the State’s analysis of pharmacy utilization in the STAR and STAR+PLUS programs from SFQ2-SFQ4.

Attachment O – Annual Children’s Medicaid Dental Service Utilization. The attachment includes the State’s analysis of dental service utilization for SFQ2-SFQ4.

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

Attachment Q – Delta Dental Exit Talking Points. The attachment provides talking points for trained staff regarding the transition from Delta Dental to other dental plans.

Attachment R – Delta Dental Exit Letter. The letter informs members of their newly-assigned plans, but let them know they could change plans by calling a toll-free number.

Attachment S – Hotline Summary. The attachment provides trends discovered and steps taken to resolve complaints and prevent future occurrences; and calls to the HHSC help desk.

Attachment T – Complaints and Appeals to Managed Care Organizations. The attachment includes STAR and STAR+PLUS complaints and appeals received by plans in SFQ4.

Attachment U – Complaints to HHSC. The attachment includes information concerning complaints received by the State in SFQ4

Attachment V – 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 W - Proposed Regional Healthcare Partnership Regions Map. The map outlines the proposed 20 regions for development of the regional healthcare partnerships.

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