Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly, Biannual, and Final Annual Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

State Fiscal Year 2013, September 2012-August, 2013

Demonstration Year 2 October 2012 –September, 2013

Federal Fiscal Year 2013, October 2012–September, 2013

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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 documents the State's progress in meeting these goals. It addresses the quarterly, bi-annual, and annual 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 24(e), 39(a) (b) and (c), 40(b) and (c), 52, 65, and 66. These STCs require the State to report on various topics, including: enrollments and disenrollments; access to care; anticipated changes in populations or benefits; outreach; 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). STC 66 requires the State to report on various topics, including: accomplishments, project status, quantitative, and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The Program Funding and Mechanics Protocol also requires the State to submit an annual report to CMS.

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 2013 SFQ4 (June-August) instead of Demonstration Year (DY) 2, Q4 ("2013 D4," covering July-September). Throughout the report, the State has identified whether the quarterly data relates to 2013 SFQ4 or 2013 D4.

During the 2013 D4, 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 10 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 Program plans by area.

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

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

Waiver activities are proceeding and detailed information on the status is included in the sections below. During Q4, the Texas Health and Human Services Commission (HHSC) focused on reviewing providers' responses to CMS feedback that was received in April and May 2013, gathering quantifiable patient impact information for each Delivery System Reform Incentive Payment (DSRIP) project, and completing the first semi-annual metrics reporting process. HHSC also provided feedback to Performing Providers regarding DSRIP milestone and metric goals in preparation for DY 2 October reporting. HHSC will continue working with RHPs to complete DY 2 October reporting, revise projects to address priority technical corrections, and submit new 3-year projects for unspent DSRIP DY 3-5 funds in federal fiscal year (FFY) 2014 Q1.

> **AS OF JANUARY 8, 2014, OF THE 1322 PLANS INITIALLY SUBMITTED, 1258 HAVE BEEN APPROVED, 41 WERE WITHDRAWN, AND 21 REPLACEMENT PROJECTS HAVE BEEN PROPOSED (TO REPLACE 23 INITIALLY SUBMITTED PROJECTS).II. ENROLLMENT AND BENEFITS INFORMATION**

This section addresses quarterly trends and issues related to STAR, STAR+PLUS and Dental Program eligibility and enrollment; disenrollment from managed care; access to care; 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 Program Operations staff following each state fiscal quarter. Unless otherwise provided, quarterly managed care data covers the 2013 SFQ4 reporting period (June-August) instead of 2013 D4 (July-September).

A. ELIGIBILITY AND ENROLLMENT

1. Market Share and Enrollment Growth

Throughout the fiscal year total enrollment in STAR remained stable, finishing the year at 2,494,060 members after starting at 2,540,062. STAR+PLUS experienced growth of about 1,700 members per quarter, rising from 403,396 in SFQ1 to 410,255 in SFQ4.

Looking at each Managed Care Organization (MCO) in the STAR Program, enrollment and total

market share for Amerigroup networks declined throughout the year. Amerigroup's market share in STAR decreased from 21.6 percent in SFQ1 to 20.6 percent in SFQ4, with every service area except Lubbock experiencing a decline in enrollment between SFQ1 and SFQ4. As Figure 1 shows, two service areas in particular lost a high percentage of enrollment: Amerigroup Bexar lost 30 percent, or 4,638 members, and the Harris service area lost 10 percent, or 12,385 members, since the start of the year. Amerigroup has indicated that in the Bexar service area, their decline in enrollment and market share was due to low name recognition for the company. In other service areas, Amerigroup's hospital and specialty network coverage appears to be impacting the plan's competitiveness, as evidenced in part by high out of network utilization figures relative to other MCOs (see the out of network analysis, found in section 2.D(4) of this report, for more information).

Molina also lost members and market share in the STAR program, declining from 4.08 percent of total STAR market share to 3.71 percent. In the El Paso service area, Molina's enrollment decreased by 28 percent, or 1,787, members since SFQ1. In the Hidalgo service area, which represents the majority of Molina's enrollment in the STAR program, the MCO lost 5,524 members (8.24 percent) since SFQ1.

In general, the MCO's decline in STAR market share was due to the default limit which was applied by HHSC to Molina in February 2013 through SFQ4. In El Paso and Hidalgo, Molina experienced significant declines in enrollment, largely due to the loss of provider groups and an ongoing reaction to Molina's rate cut in 2012.

Other notable changes included an 81 percent increase (940 members since SFQ1) in the United Jefferson service area enrollment, a 15.5 percent increase in Blue Cross Blue Shield (BCBS) Travis (1,919 members), and a 10.5 percent increase in Sendero Travis (833 members). Across all service areas, except for the declines at Molina and Amerigroup, total market share by MCO remained stable throughout the year in the STAR program.

In STAR+PLUS, consistent with the annual trend, only one STAR+PLUS MCO, Molina, experienced a net loss in market share and membership in SFQ4. Between SFQ3 and SFQ4, Molina decreased from 22.69 percent of STAR+PLUS market share to 22.16 percent, due to a decline in enrollment of 1,645 members. Since SFQ1, Molina has lost over 5,000 members, or 5.3 percent of enrollment, with a 9.8 percent decrease (1,843 members) in the Hidalgo STAR+PLUS service area, as shown in Figure 2. This drop in enrollment resulted in Molina losing 1.63 percent of total STAR+PLUS market share throughout the year. Molina's decrease in STAR+PLUS market share was distributed primarily to Superior (26.72 percent to 27.41 percent) and United (14.62 percent to 15.32 percent).

In the dental market, after the realignment caused by the departure of Delta Dental from the dental program, market shares and enrollment remained stable throughout state fiscal year 2013.

DentaQuest has held 55 percent of the market and MCNA 45 percent from SFQ2 through SFQ4. Total enrollment in the program was 2,516,118 in SFQ1 and was 2,475,673 at the close of SFQ4.

Figure 1: STAR Program Enrollment by MCO and Service Area
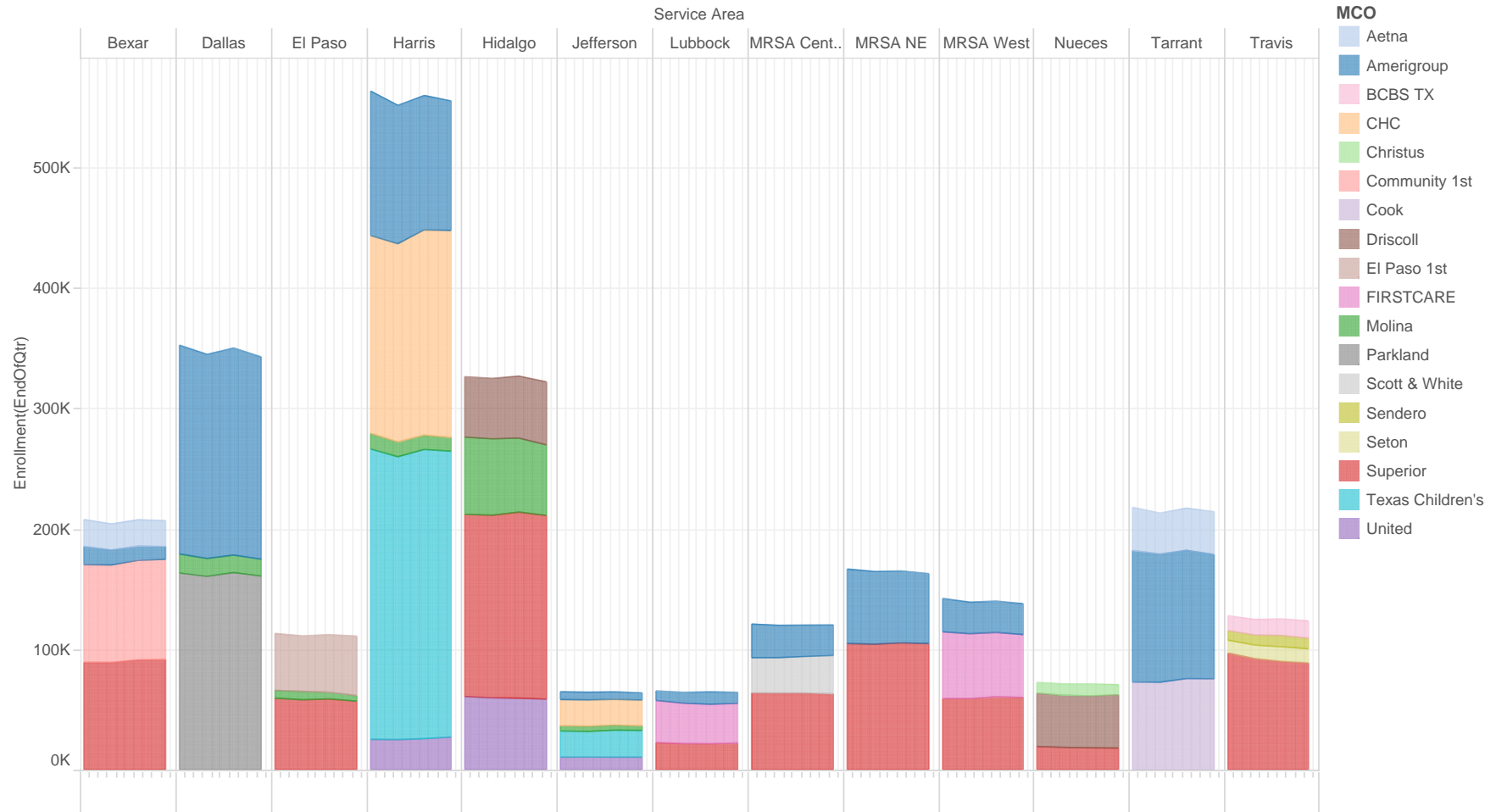
Figure 2: STAR+PLUS Program Enrollment by MCO and Service Area
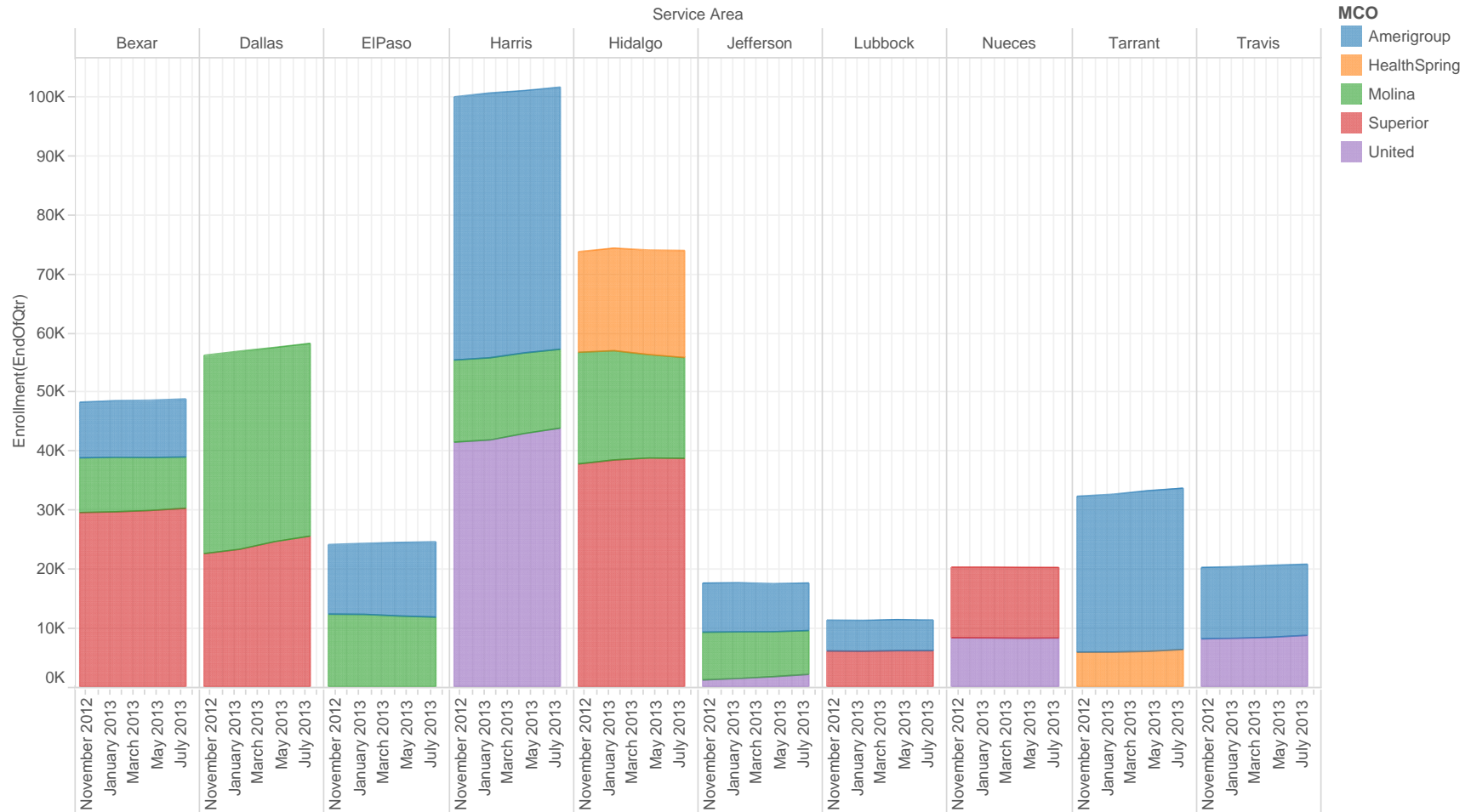
2. Enrollment of People with Special Healthcare Needs

The State's Medicaid application asks potential enrollees to identify children in the family who participate in the Children with Special Healthcare Needs (CSHCN) program. The State's enrollment broker conveys this and other information concerning potential members with special healthcare needs (MSHCN) to health and dental plans, who then determine whether the members meet the plans' assessment criteria for MSHCN. All STAR+PLUS members are deemed to be MSHCN.

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

As indicated in Attachment Q, total MSHCN counts as identified by the MCOs in STAR+PLUS in the last month of 2013 SFQ4 was 43,511 in STAR and 31,040 in STAR+PLUS.

Figure 3: Enrollment of Members with Special Healthcare Needs
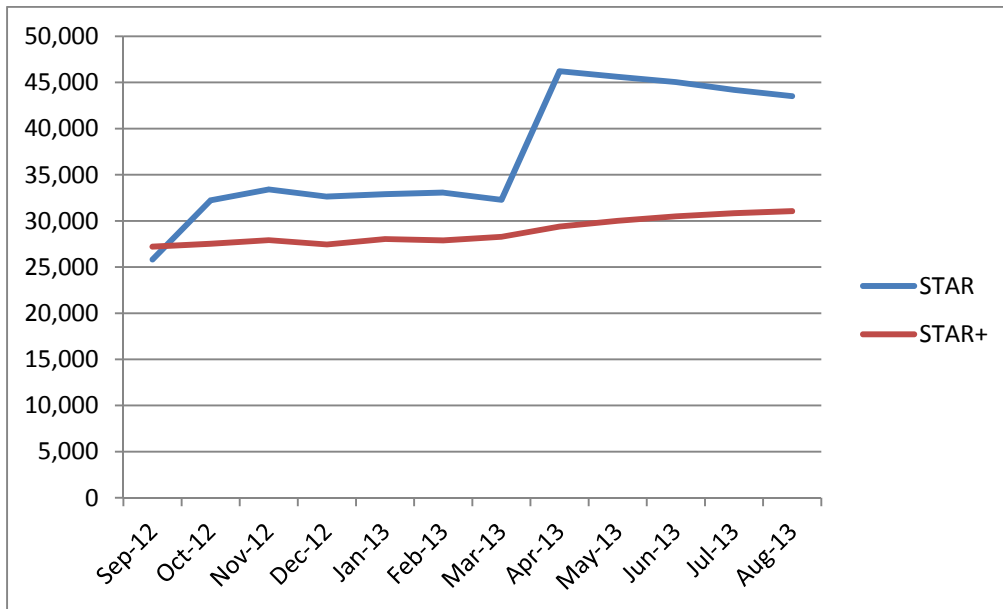
MCO identification has been the traditional method of reporting members with special healthcare needs in this report. However, the Texas Medicaid External Quality Review Organization (EQRO) also identifies children who are MSHCN using the ICD-9-CM and CPT codes from healthcare claims and encounter data. The EQRO also uses a survey-based classification (the CSHCN Screener®) to supplement the claims and encounter data. Based on these data sources, the EQRO estimated in calendar year 2012 that 15 percent of STAR children (353,463 enrollees) were children with special healthcare needs. This rate was stable over the preceding four years. Additionally, an estimated 11.52 percent of STAR children, or 353,463 enrollees, had significant acute conditions and were at risk for developing long term special health care needs. Attachment

T includes additional information on service utilization and demographic profiles of each type of health status at both the program and service area level.

According to the MCOs, which likely used a different set of criteria to identify members with special healthcare needs, there were 43,511 children and adults with special healthcare needs in STAR in 2013. HHSC is requesting the MCO's criteria for identifying the population to investigate the source of the disparity between the MCO identified numbers and the EQRO estimates.

B. ENROLLMENT COUNTS FOR THE QUARTER

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 2013 Federal Fiscal Quarter 2. Enrollment counts are based on persons, and not member months.

Figure 4: Enrollment Counts for 2013 Q2

Demonstration Populations	Total No.
Adults	298,901
Children	2,725,905
Aged and Medicare Related (AMR)	298,561
Disabled	433,583

C. DISENROLLMENT FROM MANAGED CARE

In SFQ4, the State received 25 disenrollment requests for STAR, 34 for STAR+PLUS, and none for the Dental Program. Consistent with prior trends, members or their representatives initiated all disenrollment requests in SFQ4. Five requests were determined to be justified complaints in the STAR+PLUS program and one request was determined to be a justified complaint in the STAR program in SFQ4. In total, only one individual was disenrolled in SFQ4. Figure 5 depicts total disenrollment requests in each state fiscal quarter for the 2013 state fiscal year.

Figure 5: Managed Care Disenrollment Requests – 2013 SFQ1-4
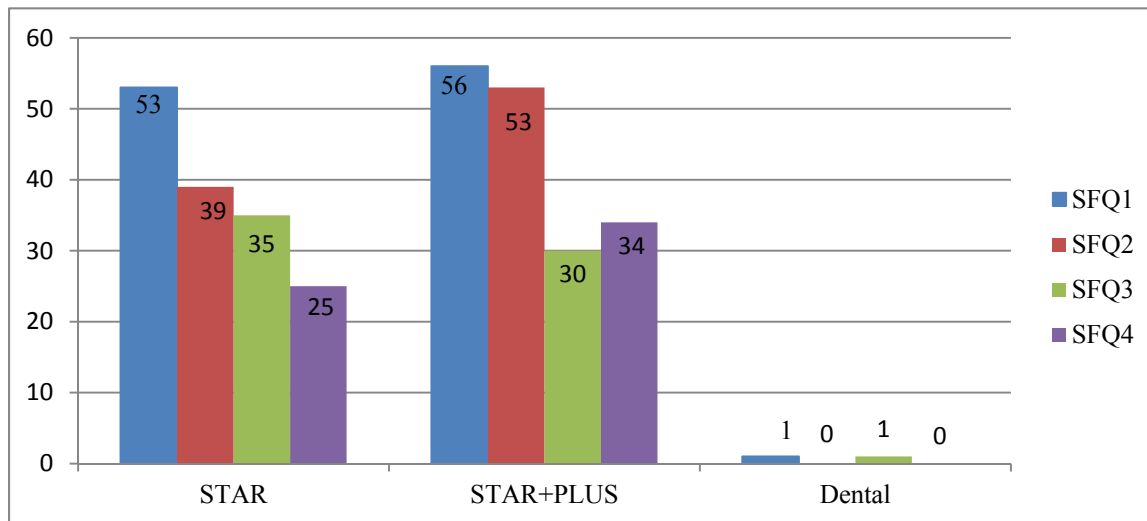
As demonstrated in figure 6, the ratio of disenrollment requests to members remained low in all three programs during the reporting period.

Figure 6: Ratio of Disenrollment Requests to Members – 2013 SFQ3-4

Program	SFQ3 Ratio	SFQ4 Ratio
STAR	1:72,041	1: 99,762
STAR+PLUS	1:13,590	1:12,066
Dental	1: 2,506,372	n/a

D. ACCESS TO CARE/MANAGED CARE DELIVERY NETWORKS

This subsection includes quarterly healthcare and pharmacy provider counts for STAR and STAR+PLUS, and dental provider counts for the Dental Program. It also addresses GeoMapping results and the use of out-of-network providers. Supporting data is located in Attachments C through K.

1. *Provider Counts in 2013*

(a) Healthcare Providers

Through each of the four fiscal quarters of 2013, provider networks remained stable in most MCO service areas. Across all service areas, since SFQ1, the total number of primary care physicians (PCPs) increased by approximately 7.8 percent in STAR and by 8.8 percent in STAR+PLUS. The number of specialists also increased by 6.6 percent in STAR and by 2.9 percent in STAR+PLUS.

This general trend masks a few declines and variations that occurred throughout the year. In the Travis service area, the number of PCPs declined throughout the year. Amerigroup saw large declines in the number of specialists in most of its STAR+PLUS service areas, in part due to difficulties contracting with specific hospital networks. Community Health Choice (CHC) reporting was flawed throughout much of state fiscal year 2013, such that after the reporting issues were resolved the SFQ4 numbers showed significant variation from SFQ1. Other than these notable changes, however, service areas remained stable and the vast majority experienced positive growth in the number of providers.

Looking at the latter portion of the year, several reporting issues were resolved and the broader trends that started in SFQ1 continued. In STAR and STAR+PLUS, network participation increased between SFQ3 and SFQ4:

- In aggregate for all provider types in 39 of 45 MCO STAR service areas (an MCO service area is the network of an MCO in a specific service area, such as Amerigroup Harris) and 23 of 24 MCO STAR+PLUS service areas;
- For PCPs in 33 of 45 STAR and 20 of 24 STAR+PLUS areas; and
- For specialists in 38 of 45 STAR and 19 of 24 STAR+PLUS areas.

After several STAR plans reported erroneous provider counts in SFQ3, several of the plans appear to have resolved the reporting issues in SFQ4:

- In both the Jefferson and Harris service areas, CHC provider counts dropped by over 15 percent in SFQ3. For example, in SFQ2, CHC reported 16,298 total providers in the Harris service area, 13,084 total providers in SFQ3, and 13,894 total providers in SFQ4. CHC has indicated that when converting from a legacy IT system to a new system, they encountered data aggregated errors. The SFQ4 count represents the accurate provider count.
- The number of reported providers in the Driscoll Nueces network spiked in SFQ2, increasing from 4,913 to 8,071 total providers. Then in SFQ3, it declined back to 5,392. In SFQ4, Driscoll reported 5,632 providers, indicating that the SFQ2 figure was erroneous. Driscoll has been placed on a corrective action plan based on this erroneous reporting.
- Seton Travis reported a decrease of 504 (17 percent) PCPs in SFQ3. Subsequent to the SFQ3 report to CMS, HHSC has learned that the decrease in the Seton PCP provider network was due the duplicative assignment of provider identification numbers to

specialists serving as PCPs. SFQ4 reporting of provider counts was consistent with the corrected SFQ3 counts.

At the time of reporting, the Amerigroup Medicaid Rural Service Areas (MRSA) continued to have unresolved reporting errors. Figure 7 shows the large changes in the reported number of specialists in the STAR Amerigroup MRSA service areas.

Figure 7

			ReportingPeriod			
			Specialists			
Program	**MCO**	**Service Area**	SFQ1	SFQ2	SFQ3	SFQ4
STAR	Amerigroup	MRSA Central	6,555	5,814	5,287	6,156
		MRSA NE	4,820	4,556	3,003	3,373
		MRSA West	5,213	5,029	4,107	4,848
		Total	16,588	15,399	12,397	14,377
	Total		16,588	15,399	12,397	14,377

Scott and White MRSA Central reported a decrease of 484 (38.5 percent) in SFQ3 PCPs due to prior erroneous reporting that categorized specialists as PCPs, but then in SFQ4 reported an additional 1,000 PCPs. At the time of report drafting, this issue was also unresolved. Preliminary analysis indicated that some specialists outside of the MRSA Central service area were erroneously included.

HHSC and the health plans are investigating the potential sources of these reporting discrepancies. The plans are subject to liquidated damages for erroneous reporting.

Total provider terminations remained stable in the aggregate for STAR and decreased in STAR+PLUS in SFQ4. [1] Terminations at Superior increased significantly in the STAR program, rising from 0.9 percent of total providers to 1.8 percent of total providers terminated in SFQ4. Superior Bexar experienced 201 provider terminations, compared to 92 in SFQ3, or 2.9 percent of providers, due to Superior's termination of all ophthalmologists. Superior indicated that they terminated their ophthalmologists because they have providers through their vision vendor Opticare. Superior's MRSA Northeast (NE) provider terminations also increased, rising from 32 (0.6 percent) to 116 (2.2 percent) for the same reason. United Jefferson terminations increased from 65 to 184 due to two large practices leaving the United network and United Harris terminations increased from 81 to 200 due to practices leaving.

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[1] Program 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.

(b) Pharmacy Providers

The STAR and STAR+PLUS pharmacy networks declined in 2013 SFQ4. The STAR program lost 108 pharmacies in total based on declines in Superior service areas of about 12 pharmacies per service areas, and the STAR+PLUS program lost 91 pharmacies for the same reasons. These changes in the Superior networks resulted in a 0.6 percent decline in the number of STAR pharmacies and a 1 percent decline in STAR+PLUS pharmacies.

(c) Dental Program Provider Counts

The number of dental providers increased in both dental plans. In DentaQuest, the number of providers increased by 1.4 percent between SFQ3 and SFQ4, consistent with growth in every quarter of fiscal 2013. In SFQ4, the number of main dentists increased by 2.7 percent, while the number of specialists dropped by 8.5 percent (51 providers). The number of providers in MCNA's network increased by 2.0 percent, restoring the total number of providers to the volume at the beginning of the year, after a small decline in SFQ2. In SFQ4, MCNA gained 92 main dentists and lost 8 specialists.

In SFQ4, provider terminations increased, but still remained a small proportion of each plan's total number of providers. There were 79 terminations at DentaQuest and 99 at MCNA. These are aggregate counts, and have not been reduced to account for network providers that may have left more than one dental network. Providers were most commonly terminated due to provider relocation.

2. *Primary Care Providers and Main Dentists Accepting New Members*

This section 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, C, and D. STAR and STAR+PLUS plans submit quarterly files identifying the number of PCPs who are accepting new Medicaid patients, described here as "open panel" PCPs. Likewise, dental plans identify the number of main dentists accepting new Medicaid patients, described here as "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 discuss these monitoring results.

Consistent with prior fiscal quarters, most plans in STAR and STAR+PLUS met the 80 percent benchmark for the percentage of PCPs who were open panel in SFQ4. Only one MCO service area in STAR+PLUS fell below the standard, and 80 percent of MCO service areas were at or above the standard in the STAR Program.

In the STAR program, almost all of the MCO service areas that did not hit the 80 percent benchmark were in either the Amerigroup or Superior networks. Cook Tarrant and FirstCare Lubbock were the only two exceptions. Cook Tarrant fell below the benchmark with 61.6 percent of PCP's open panel and FirstCare Lubbock was at 78.5 percent, consistent with prior trends.

Three of Superior's 9 STAR service areas service areas were below the 80 percent benchmark. Travis and MRSA Central were notably well below the standard; in both service areas rates of open panel PCPs were below 61 percent. In contrast, Superior's Bexar network was within 0.6 percent of the standard.

Five of Amerigroup's 16 service areas were also below the benchmark. In several of these service areas, Amerigroup continues to report that their own figures show they are in compliance. HHSC is investigating the source of this discrepancy.

The 80 percent open panel standard, however, does not take into consideration the number of PCPs who are open panel relative to an MCO's member enrollment. A plan may have a lower than average percentage of open panel PCPs, but could still have a higher ratio of open panel PCPs to the number of members enrolled, depending on the MCO's provider and member enrollment ratios.

In fact, in both the STAR and STAR+PLUS programs, the percentage of open panel PCPs was only weakly correlated to the number of members per open panel PCP (~0.21). In the STAR program, for example, only 56.2 percent of PCPs were open panel in the Amerigroup Travis network. However, there were only 15.1 members per open panel PCP, which was much lower than many MCOs with open panel percentages approaching 100 percent. In conjunction with high rates of access to PCPs within 30 miles of members residence, this may be why HHSC has seen no major impacts on access to care for plans in the Travis service area that have open panel percentages below 80 percent.

Figure 8 shows the number of members per open panel PCP by service area, MCO, and program. Texas Children's and Cook Tarrant are outliers in the Texas Medicaid managed care data set in terms of the number of members per PCP. Overlapping this data with the open panel percentages, it is clear that these two service areas are the primary areas where low open panel percentages directly coincide with higher than average number of members per open panel PCP.

Figure 8: Number of members per open panel PCP in MCO service area
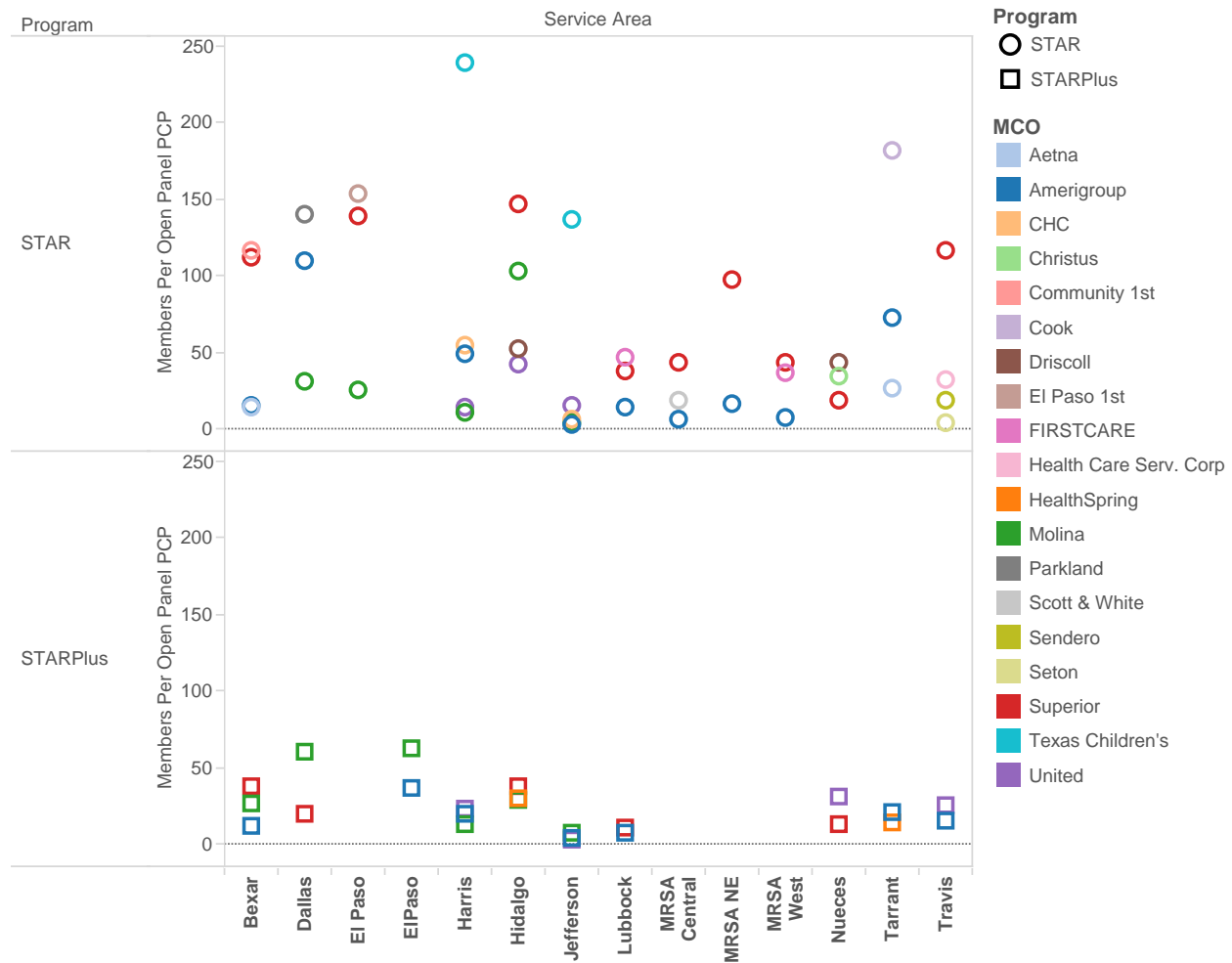
Both dental plans met the State's 90 percent standard for main dentists with open practices in every fiscal quarter of 2013.

3. GeoMapping Results

Because there is a one quarter lag between the end of each state fiscal quarter and the completion of HHSC's compliance analysis, this report presents analysis for 2013 SFQ3. The data below is based on plans' self-reported GeoMapping data. Comparisons to HHSC Strategic Decision Support (SDS) analysis are made below where relevant. The SDS-reported figures in SFQ3 included dual-eligible for STAR+PLUS, whereas the plans excluded dual-eligible to account for acute care services delivered through Medicare. In future reports, HHSC will run SDS GeoMapping data without dual-eligibles in order to make a direct comparison.

Access to behavioral health providers and hospitals in the Dallas service area is excluded from the program wide calculations below due to the presence of the NorthSTAR behavioral health program.

a. *STAR and STAR+PLUS Summary*

The SFQ3 results demonstrate that, as a whole, the STAR and STAR+PLUS programs exceeded the State's 90 percent benchmarks for most provider types in 2013 SFQ3. When compared to 2013 SFQ2, program totals improved or remained stable for almost all provider types. Most plans also met pharmacy benchmarks, and access to main dentists remained high.

b. *STAR GeoMapping*

In SFQ3, access to behavioral health hospitals improved, access to allergists and otolaryngologists (ENTs) in the MRSAs continued to fall below benchmarks, and access to other physician types either remained stable or increased. Most of the plans that failed to meet the benchmark experienced difficulty primarily for outpatient behavioral health hospitals and allergists in the Hidalgo, Nueces, MRSA West, and MRSA Northeast service areas.

Access to outpatient behavioral health hospitals continued to improve in SFQ4, with an additional 1.6 percent of adults and 0.5 percent of children in the STAR program gaining access within the mileage standard. These improvements were caused by gains in the MRSA West service area for Amerigroup and Superior networks. However, plans in this service area, as well as Hidalgo and Nueces remained below the 90 percent benchmark.

The reported total percentage of adults with access to allergists in STAR in SFQ2 was revised upwards by three percent due to a data entry error in calculating the program totals. After this correction, the total percentage of adults with access to an allergist has remained constant at 94 percent since SFQ1. However, access to allergist continued to be an issue in the MRSA West service area.

Figure 9: STAR Program – Percent of Children with Access to One Provider in 2013
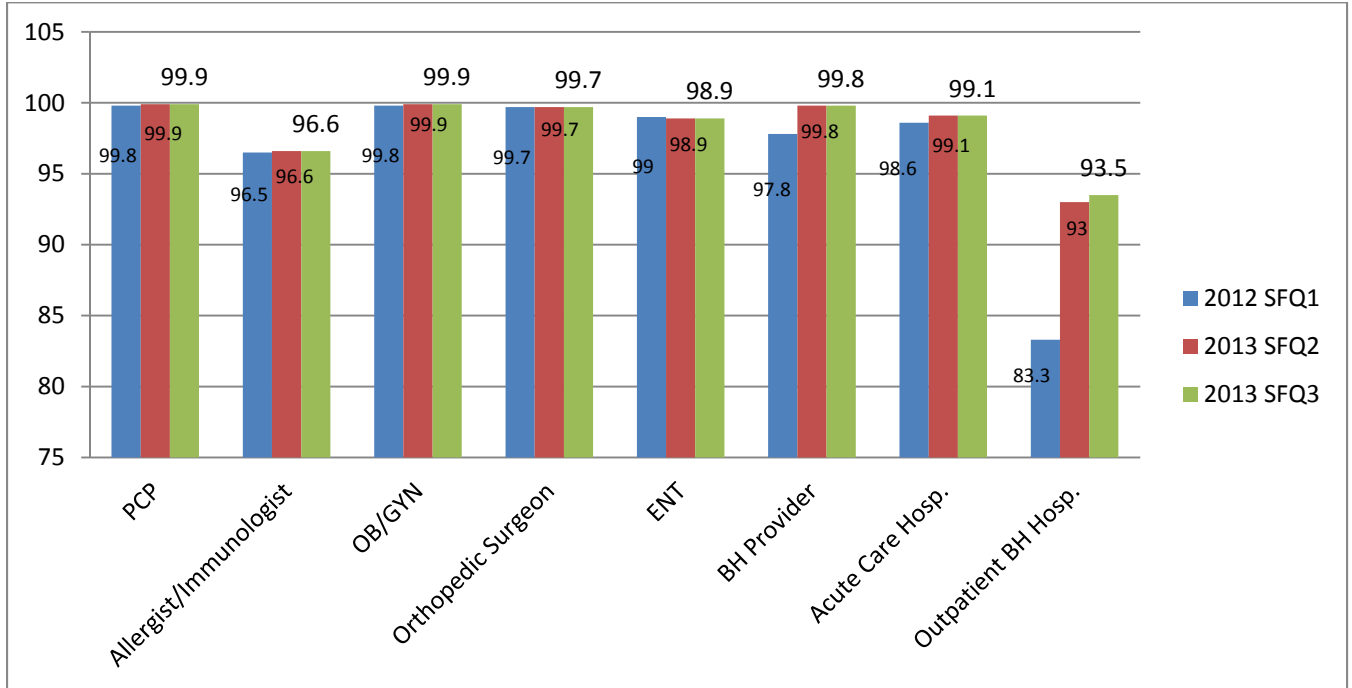
Figure 10: STAR Program – Percent of Adults with Access to One Provider in 2013
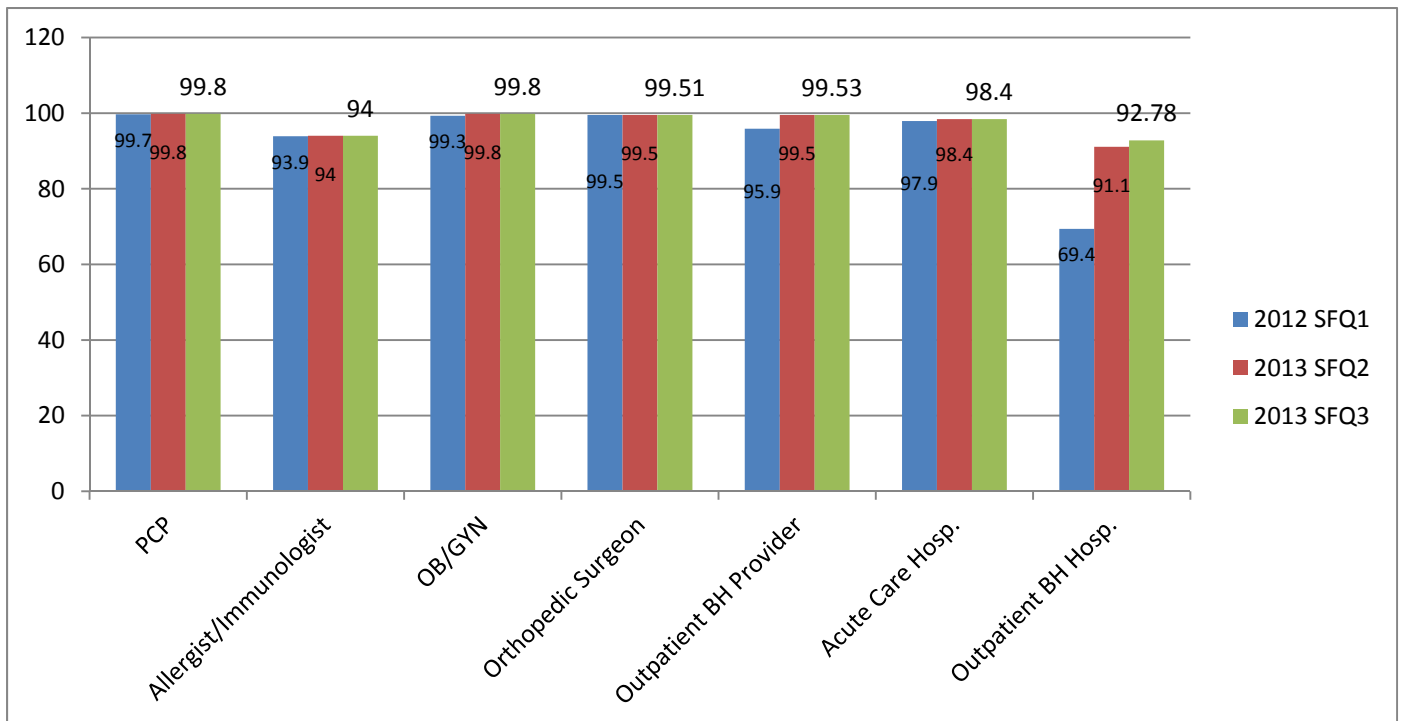
All three plans operating in the MRSA West service area fell significantly below the allergist/immunologist benchmark. Superior has indicated that the limited number of allergists and immunologist providers in the MRSA West is due to the fact that providers are resistant to contract with Medicaid MCOs since their practice is already at capacity with higher paying insurance programs. FirstCare has indicated that it has contracted will almost all allergist/immunologists in the area, and still can only provide access within the mileage standards for less than half of their members. HHSC is not aware of any access to care issues but will continue to monitor the MRSA West service area. At the current time, access limitation to allergists/immunologists in the MCO networks appear to be based on provider availability in the service area.

In STAR, the MRSA West service area also continued to experience lower than standard rates of access across plans for access to ENTs (measured only for children). In MRSA West, Amerigroup and FirstCare fell below the ENT benchmark for children, though Superior, the largest plan in the region, maintained access to ENTs within 75 miles for 92.4 percent of members. Access to ENTs for children declined slightly in Amerigroup from 76.6 percent to 75 percent and increased from 75 percent to 76 percent in FirstCare between SFQ2 and SFQ3. In the prior fiscal quarter, Amerigroup and FirstCare cited unsuccessful contracting efforts and a lack of Medicaid-enrolled ENTs as reasons for non-compliance—though this is somewhat mitigated by Superior's adequate network with a larger member enrollment volume. To ensure access to care, plans arranged for services through single-case agreements with providers in or around the service area.

    c. *STAR+PLUS GeoMapping*

Because the MRSAs are not included in the STAR+PLUS program, access to allergists and ENTs was higher in the STAR+PLUS program, with all plans hitting the benchmarks for these types of providers. Among the ten STAR+PLUS service areas, Hidalgo was the only service area where plans fell significantly below benchmarks. In the Hidalgo service area, the MCOs met all benchmarks except for access to outpatient behavioral health hospitals. HealthSpring reported that less than 77 percent of members had access to a behavioral health hospital within 75 miles, and Superior reported that less than 83 percent had access within 75 miles, while Molina met the benchmark with 100 percent access for both children and adults.

Compared to SFQ2, access to acute care hospitals in the Nueces United network improved, moving from 82.4 percent to 97.4 percent for adults and for children from 69 percent to 93.2 percent. Molina also reported that the Hidalgo network actually complied with access standards for cardiologists, due to their incorrect identification of cardiologists in prior quarters' systems files. The Q2 program totals have been adjusted accordingly in Figure 12 below, resulting in an increase from 99.3 percent to 99.9 percent. Other than these two improvements, access remained stable in the STAR+PLUS network in SFQ3.

Figure 11: STAR+PLUS Program – Percent of Children with Access to One Provider in 2013
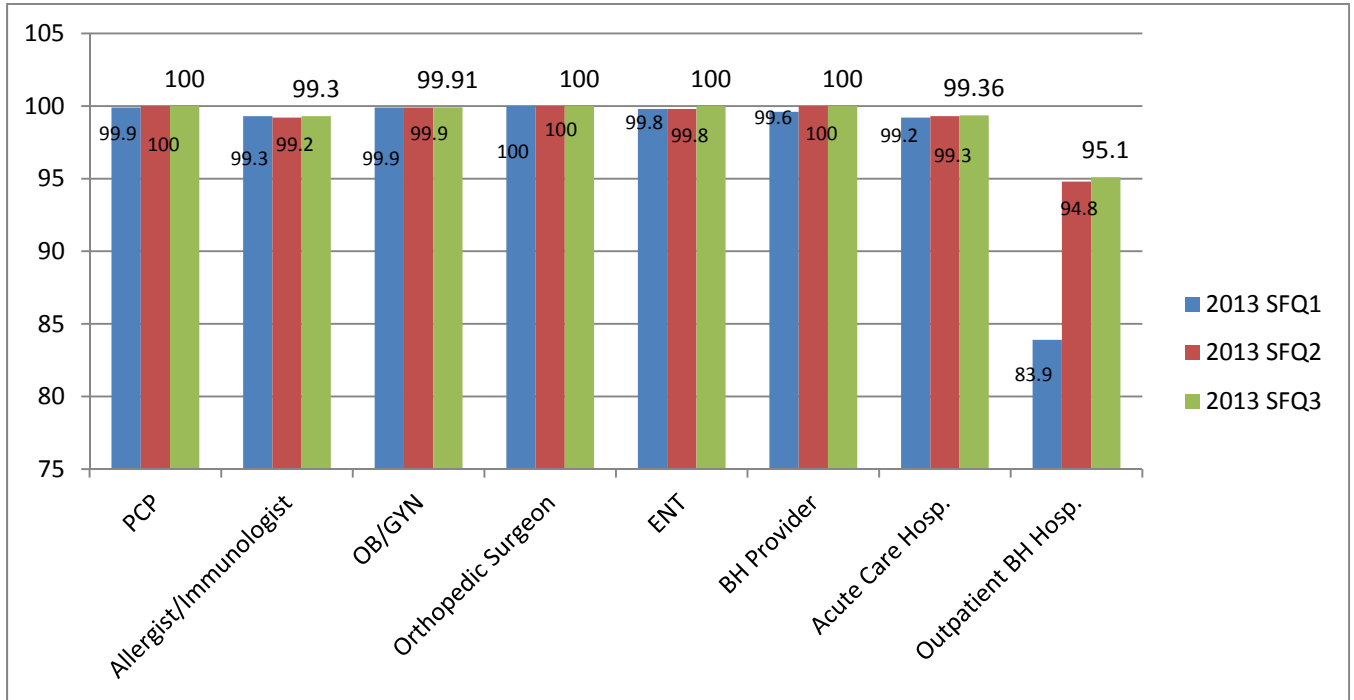
Figure 12: STAR+PLUS Program – Percent of Adults with Access to One Provider in 2013
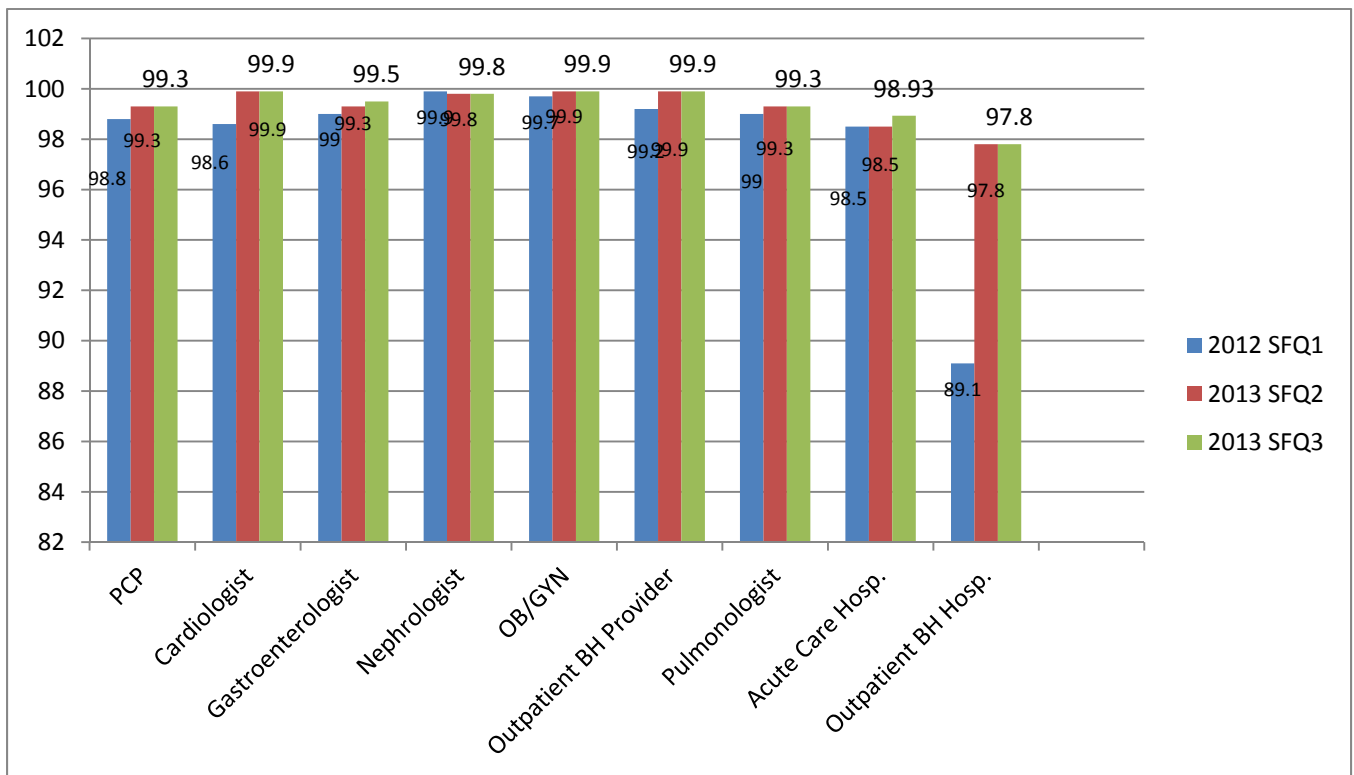
d. *Pharmacy GeoMapping*

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; and
- 90 percent – access to a 24-hour pharmacy in all counties within 75 miles.

The majority of MCO service areas met these standards in SFQ3. In the STAR and STAR+PLUS programs, for both children and adults, the Hidalgo service area and the MSRAs continued to be the primary service areas where plans experienced difficulty meeting access benchmarks. In the STAR program, for example, all eight MCO service areas that fell below the urban two mile benchmark for adults were in either the Hidalgo or MRSA service areas. Additionally, almost all MCOs missed the benchmark for access to a 24 hour pharmacy in the Hidalgo and MRSA West service areas. Access in suburban areas continued to lag behind benchmarks in Bexar and Jefferson, as well as the MRSA's, consistent with prior fiscal quarters.

Access reported by SDS was on average similar to that of the plans, but there were a number of instances where the reported access varied by more than ten percent between the two sources. In the STAR program, there were typically five or six service areas where the variance between SDS and the self-reported figures was greater than ten percent, with SDS typically reporting higher rates of access than the MCOs. In STAR, most of these discrepancies occurred in either Molina or Amerigroup networks and were especially common in the rural service areas. The average (absolute) difference between the two sources regarding access to a single pharmacy provider was between 2.6 and 10 percentage points in STAR and STAR+PLUS. HHSC is investigating the source of the larger discrepancies.

Figure 13 depicts the percentage of MCO service areas meeting pharmacy access standards for access to one provider, based on the self-reported rates of access (which were generally more conservative), with null values in suburban and rural areas assumed to be non-applicable (as confirmed by SDS analysis).[2]

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[2] In the El Paso region, fewer than 25 members live in a rural county. The access values for these rural counties have been excluded from the calculations above as outliers based on extremely small samples.

Figure 13: Percent of Service Areas Meeting Pharmacy Access Standards 2013 SFQ4
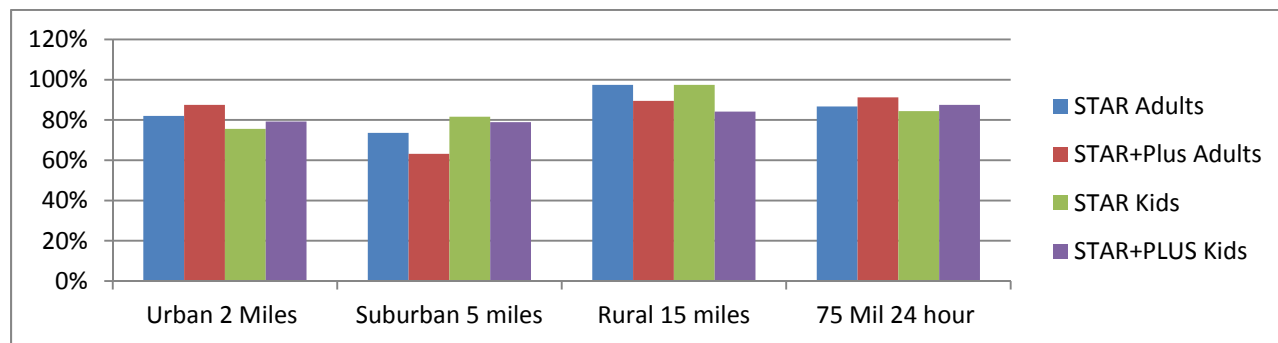
The percentage of children and adults across all service areas is not available at this time, due to the way the plans report their data.

> *e. Dental GeoMapping*

Between SFQ2 and SFQ3 access to all dentist types improved in aggregate, though the self-reported improvements have not been verified by HHSC's SDS analysis at the time of reporting.

Dental GeoMapping results are divided into 11 Texas regions. Within each region, the dental plans report on the percentage of members in urban and rural areas with access to main dentists, endodontists, oral surgeons, orthodontists, periodontists, and prosthodontists.

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

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

For main dentists, each member must have access to two providers within the required distance, and at least 95 percent of members must have access to specialists.

In SFQ3, 99.8 percent of members in urban areas and 99.5 percent of members in rural areas had access to at least two main dentists, representing a one percent improvement compared to SFQ2 for rural members. Both the Upper Rio Grande service area and the West service area had instances of access to a main dentist that were below 90 percent. In the Upper Rio Grande service area, both DentaQuest and MCNA fell below the benchmark for rural members, though MCNA reported a significant improvement compared to SFQ2, with access improving from 24.8 percent to 85.4 percent, due to a correction in the data reporting methodology (which has not been confirmed by SDS analysis at this time). In the West service area, approximately 75 percent of members in rural areas had access to two main dentists.

Access to oral surgeons and orthodontists continued to improve in SFQ3, due to improvements in the High Plains and West service areas within the MCNA network for oral surgeons—though these improvements have also not been confirmed by SDS.

In the prior fiscal quarter access to one specialist was higher for endodontists, periodontists, and prosthodontists than access to two specialists. However, in SFQ3, reporting changes in MCNA networks appear to have brought the rates into alignment.

Figure 14: Percent of Dental Program Members with Access to Two Providers in 2013
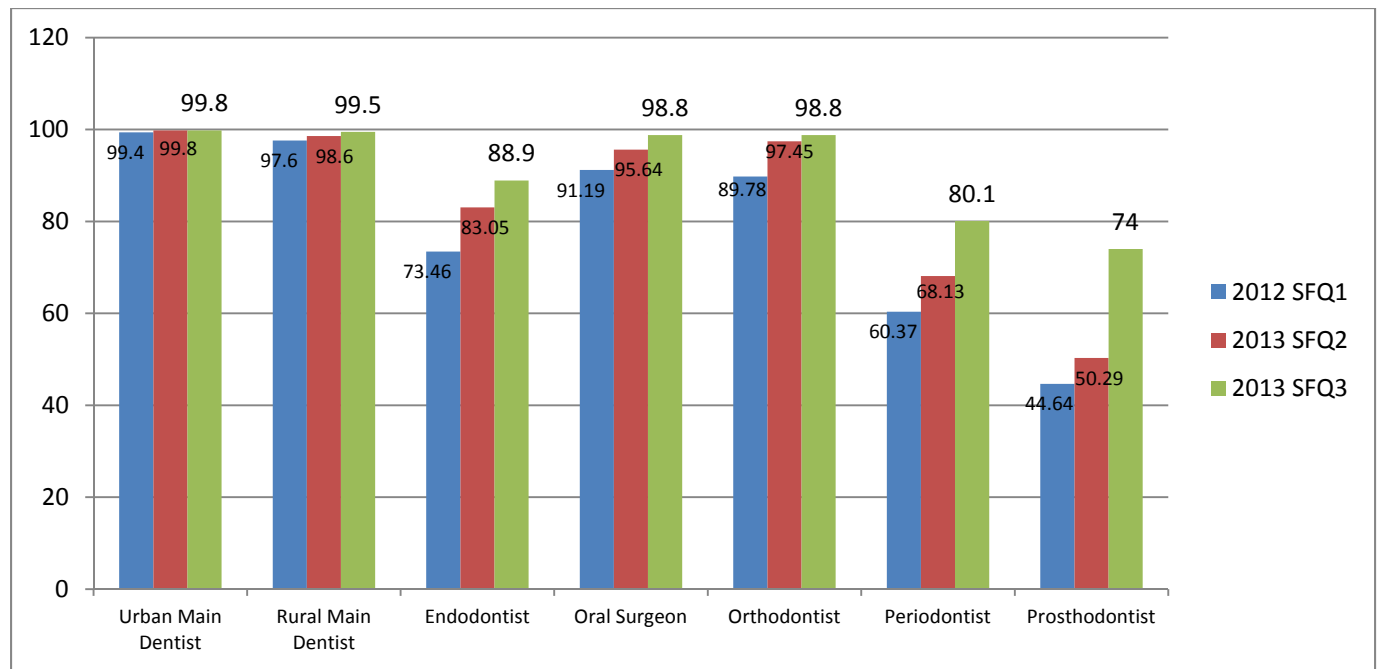
Though the changes between SFQ2 and SFQ3 described above have not been confirmed by SDS at this time, the dental plans' data was generally consistent with SDS' findings. For 154 data points (2 plans, 11 regions, and 7 measures) in the access to 2 provider measures, only 17 data points were substantially divergent. Fifteen of the 16 instances of divergence in SFQ3 occurred among specialist networks. Compared to SDS, DentaQuest showed:

- o Higher access to two main dentists within 75 miles in the Upper Rio Grande service area;
- o Higher access to prosthodontists in MetroPlex, Upper South, and Lower South service areas;
- o Lower access to periodontists in Southeast and Lower South Texas;
- o Lower access to endodontists in Southeast and High Plains; and,
- o Lower access to oral surgeons in Northwest.

Compared to SDS, MCNA showed:

- Higher access to 2 main dentists within 75 miles in the Upper Rio Grande service area;
- Higher access to oral surgeons in the High Plains service area;
- Higher access to orthodontists and periodontists in Upper Rio;
- Higher rates of access to prosthodontists in MetroPlex and Upper South; and,
- Lower access to endodontists in Upper Rio Grande.

In some of these instances, the variance between the SDS reported figure and the MCO reported figure was 90 percent or more, indicating likely data entry or calculation errors from one of the data sources. HHSC is investigating the source of these discrepancies.

4. Out-of-Network Utilization

As required by Texas law,[3] the State monitors health and dental plans' use of out-of-network facilities and providers.[4] In each service area, out-of-network utilization should not exceed the following thresholds:

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

If a plan can demonstrate that it made good faith efforts to contract with an out-of-network provider to no avail, it can request "special consideration" when it exceeds a utilization threshold. If the State grants the special consideration, it removes the non-contracted provider from the plan's compliance calculations. The charts below show out-of-network in 2013, *before* special consideration calculations were applied. Likewise, the narrative focuses on pre-special consideration figures, unless otherwise noted.
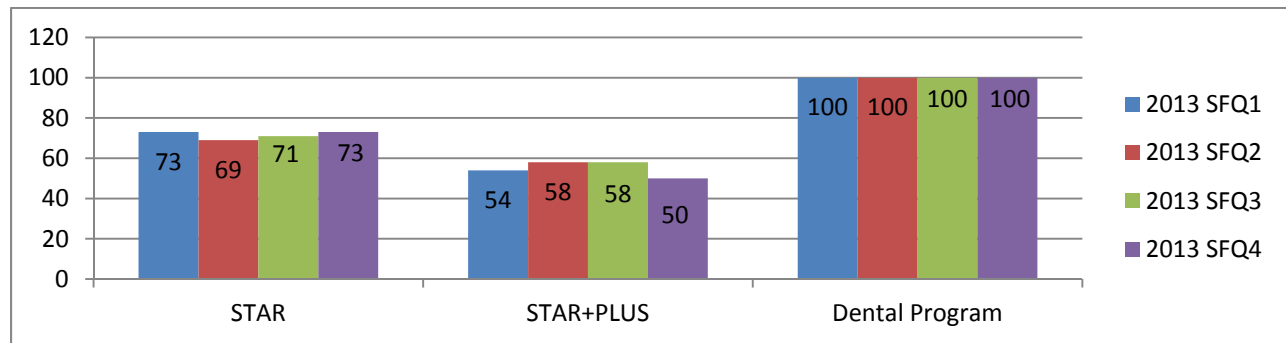
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[3] Tex. Gov.'t Code §533.005(a)(11).

[4] 1 T.A.C. §353.4(e)(2).

Figure 15: Percent of Service Areas Meeting All Out-of-Network Thresholds in 2013

In the STAR program, 32 of 45 MCO service areas met all out-of-network standards before special consideration in SFQ4, the same as the prior fiscal quarter. Out-of-network utilization was generally high in the Dallas, Harris, Tarrant, and Central MRSA, especially in Amerigroup networks, in some instances exceeding 50 percent OON. In these service areas, however, at least one MCO met the applicable standards (even before special consideration). After applying special consideration, HHSC deemed 42 of 45 of the STAR MCO service areas contractually compliant with OON requirements in SFQ4.

Figure 16 depicts the average out-of-network for the STAR program, aggregated by each MCO specific service area. The average inpatient OON increased from 7.8 percent to 8.7 percent, emergency room (ER) out-of-network increased from 12.5 percent to 13.2 percent, and outpatient (or "other") out-of-network decreased from 11.7 percent to 9.3 percent.

Figure 16: Average STAR Out-of-Network Utilization in 2013
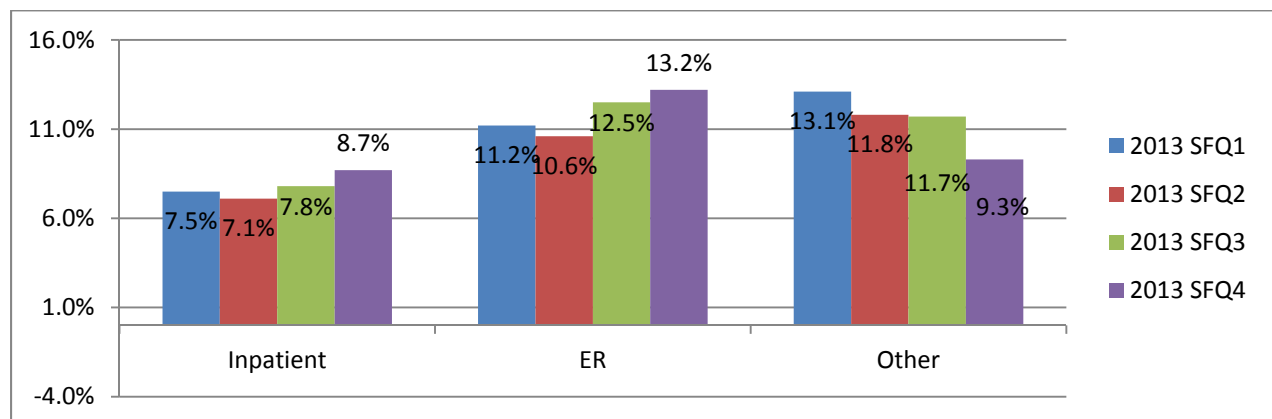
The decline in outpatient out-of-network was primarily due to large decreases in Amerigroup's MRSA Northeast, MRSA West, and Bexar service areas. The increase in inpatient and ER out-of-network was largely due to increased out-of-network in Molina's Dallas and El Paso service areas and Community First' Bexar service area. Outside of these changes in the Amerigroup, Molina, and Community First networks, out-of-network utilization in STAR remained largely stable.

In STAR+PLUS, 14 of 24 plans met the inpatient out-of-network standard, 13 of 24 met the standard for emergency room utilization, and 22 of 24 met the standard before special consideration for outpatient expenditures. In total, only 50 percent of STAR+PLUS MCO service areas met all out-of-network standards. However, after applying special consideration, HHSC deemed 20 of 24 MCO service areas contractually compliant with out-of-network requirements in SFQ4.

In the STAR+PLUS program, as Figure 17 shows, inpatient out-of-network increased from 14.5 percent to 16 percent, ER out-of-network increased from 15.4 percent to 18.8 percent, and other out-of-network declined from 14.6 percent to 11.7 percent.

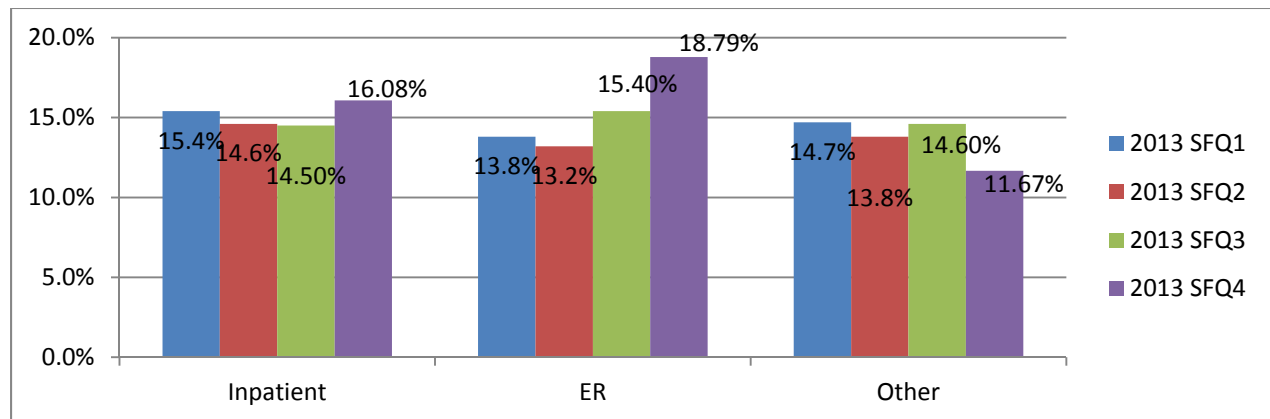**Figure 17: Average STAR+PLUS Out-of-Network Utilization in 2013**

Most of the changes in average out-of-network were driven by changes in Amerigroup service areas. Declines in outpatient out-of-network in STAR+PLUS were due to decrease in Amerigroup service areas. Likewise, the change in inpatient out-of-network was also due to Amerigroup (in conjunction with a Molina Dallas spike). Other major changes included an increase from 24 percent to 43 percent in ER out-of-network in the United Harris network, and a drop in out-of-network in the HealthSpring Tarrant service area for outpatient out-of-network from 23 percent to 8 percent and inpatient out-of-network from 32 percent to 21 percent.

The health plans that were not able to meet the performance thresholds cited two primary factors for high out-of-network utilization: Difficulty contracting with certain hospitals and out of the service area utilization for emergency services.

Amerigroup reported contract discussions in several service areas that were approaching finalization in SFQ4 that may significantly reduce out-of-network utilization in those areas. Amerigroup has completed contract negotiations with a major hospital chain that will likely result in significant reductions in ER and outpatient out-of-network utilization in service areas where they have high out-of-network utilization. The State will continue to monitor these plans, and will require corrective action or other remedies if appropriate.

Dental plans continued to report out-of-network utilization well below the 20 percent threshold at less than 0.5 percent. As shown in Figure 18, in the Dental Program, the 20 percent standard for "other services" applies to out-of-network dental services.[5]

Figure 18: Average Dental Program Out-of-Network Utilization in 2013
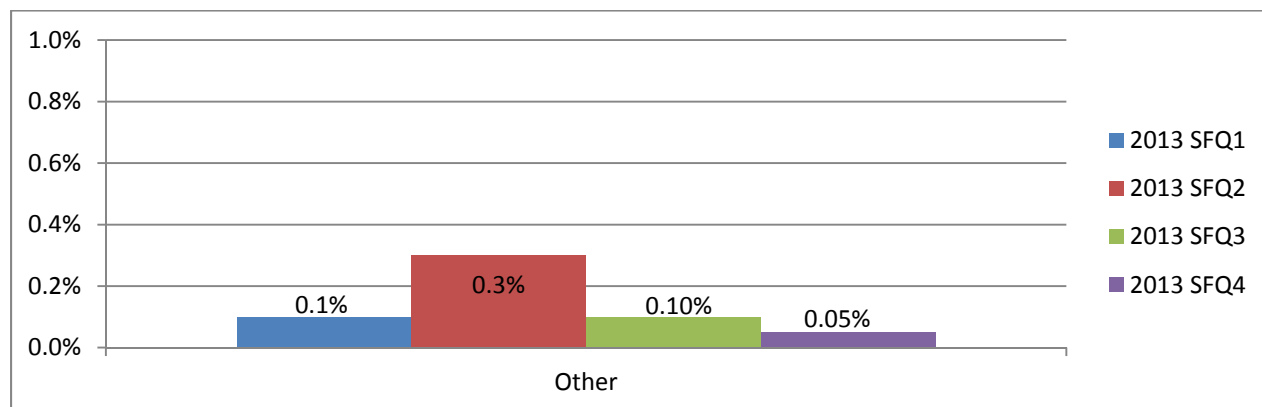
5. *Twenty-four Hour Service Availability*

After-hours access is especially important on a recurring basis for access to PCPs, 24 hour pharmacies, emergency hospital care, and behavioral health services. The requirements and relevant analysis of each are described below for purposes of fulfilling the annual reporting requirement of special terms and conditions number 39(c) of the 1115 waiver.

a. *General emergency services*

Emergency services must be provided to members without regard to prior authorization or the provider's contractual relationship to the MCO (8.1.3 of the Uniform Managed Care Contract), and general patterns of access are addressed in the out-of-network section of this report.

The MCO must provide that if medically necessary covered services are not available through network providers, the MCO must, upon the request of a network provider, allow a referral to a non-network physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five (5) Business Days after receipt of reasonably requested documentation. The MCO must fully reimburse the non-network provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC in 1 T.A.C. §353.4. HHSC at times works to facilitate such

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[5] Q1 and Q3 have been revised downward (by less than 0.5 percent) due to erroneous reporting in the chart in SFQ3.

single-case agreements when necessary.

Access to a behavioral health services hotline on a 24 hours basis is addressed in the hotline performance section of this report.

b. *Twenty-four hour PCP Access*

HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, seven days per week and outlines very specific criteria for what constitutes compliance.[6] Each MCO is also required to systematically and regularly verify that covered services furnished by PCPs meet the 24/7 access criteria and enforce access standards where the providers are non-compliant.

HHSC recently requested the results of each MCO's efforts to systematically evaluate continuous access to PCPs. Most MCOs were able to provide survey results for after-hours access and appointment availability, though a few did not respond in time for this publication and a few did not conduct an after-hours survey. HHSC is following up with these MCOs to gather additional information and ensure that the MCO is rigorously evaluating access to PCPs.

Figure 19 shows the results of the after-hours surveys using 95 percent confidence intervals. Estimated compliance rates varied widely between MCOs, likely indicating differences in how the surveys were conducted.

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[6] See Sections 8.1.3.1, 8.1.3.2, and 8.1.4.2. of the TX HHSC Uniform Managed Care Manual. See also Title 28 of the Insurance code, Rule 11.1607 that PCPs be available and accessible 24 hours per day, seven days per week within an HMO's service area.

Figure 19: Percent of Providers with HHSC Compliant After Hours Coverage by MCO
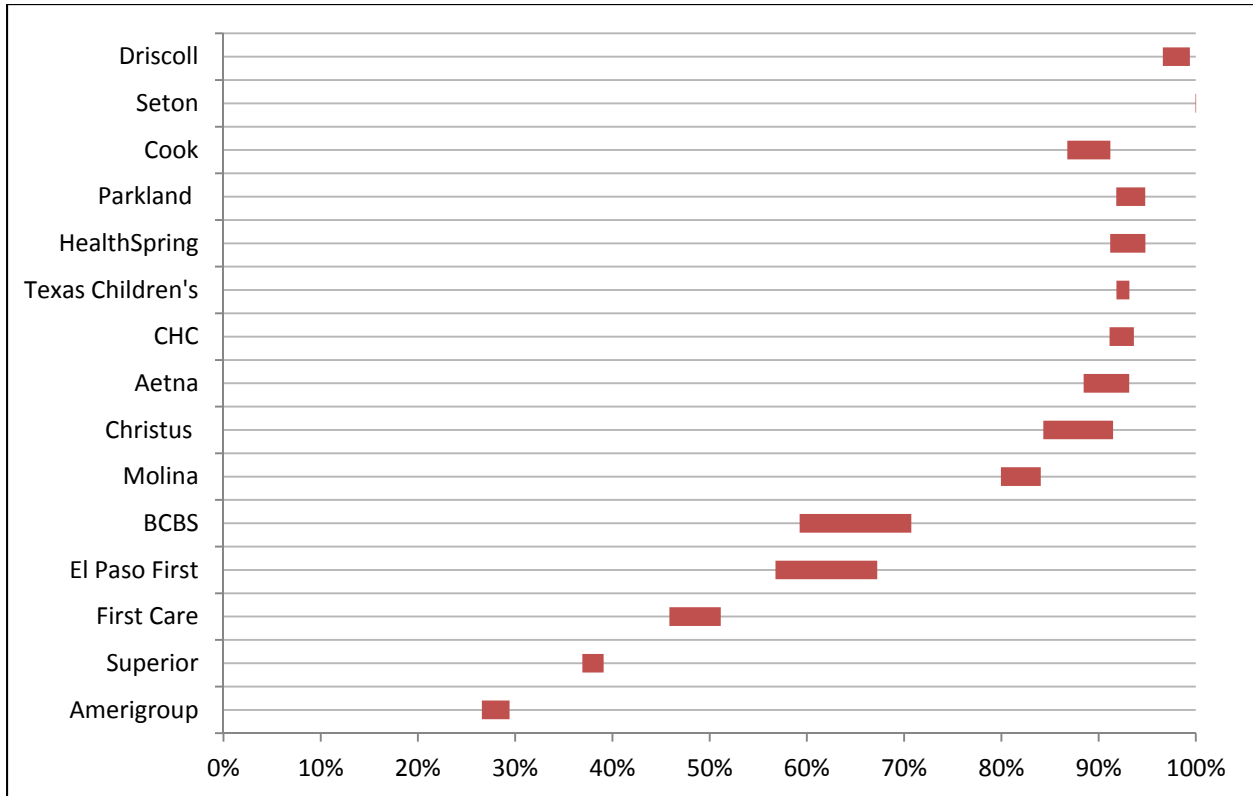
The two largest MCOs in terms of member enrollment and provider networks reported very detailed survey methodologies with compliance rates below 50 percent. Rates of access reported by BCBS, El Paso First, FirstCare, Superior, and Amerigroup are consistent with member surveys conducted by the EQRO showing difficulty accessing PCPs after hours.

Sixty-one percent of STAR+PLUS Medicaid only, 47 percent of caregivers of children, and 48 percent of STAR adult members had to wait to schedule an appointment due to limited work hours or few appointments available, with 21 percent of STAR child caregivers saying this usually or always an issue.[7]

Additionally, recent member surveys have revealed that of the 30 percent of STAR adult members who went to the ER in 2011, one third "went to the emergency room for care because

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[7] Texas Medicaid STAR+PLUS Adult Medicaid Only Draft Member Survey Report, Contract Year 2012, 16; Texas Medicaid Child Survey Draft Report, Contract Year 2012, 14; Texas Medicaid STAR Program Adult Member Survey Report, Contract Year 2012;

they could not get an appointment at their doctor's office or clinic."[8] Among caregivers of children in STAR "over half said they visited the ED because they could not get an appointment at a doctor's office or clinic as soon as they thought their child needed care."[9] According to the EQRO, "this type of potentially preventable ED visit was associated with lower personal doctor ratings and lower scores on doctors' communication, independent of other demographic, health status, and health plan factors." Most individuals did not contact their personal doctor, and according to the EQRO, "lack of after-hours access to their personal doctor was one of the most important reasons why they did not contact their personal doctor."[10]

The reported rates of PCPs offering after-hours care is also consistent with nationally reported figures across all health systems (Medicaid, commercial, Medicare, etc.). "According to a 2009 cross-national survey, only 29 percent of U.S. primary care practices offered an after-hours arrangement whereby patients could see a physician or nurse without visiting the ED."[11]

The EQRO has recommended to HHSC that "STAR network providers should be encouraged to extend appointment opportunities by staggering physician regular work hours, or adopting an 'advanced access' system."[12] HHSC has asked the EQRO to provide additional research on the issue and is following up with the MCOs to emphasize the importance of administering the surveys, conducting root cause analysis, and encouraging PCPs to implement 24/7 access.

c. Pharmacy

In SFQ4, 95 percent of STAR Adults, 96.5 percent of STAR children, 97.7 percent STAR+PLUS adults, and 94 percent of children in STAR+PLUS had access to a 24 hour pharmacy within 75 miles of their residence. Hidalgo and MRSA West were the only service areas where MCOs failed to meet the 90 percent standard. Otherwise rates of access exceeded 90 percent in every service area.

E. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

The State has requested amendments to the 1115 waiver to implement legislatively-mandated changes enacted during the 83rd Regular Session. The purpose of these changes is to create greater continuity of care for Medicaid clients and further coordinate physical and behavioral

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[8] Texas Medicaid STAR Program Adult Member Survey Report, Contract Year 2012, 14.

[9] Texas Medicaid Child Survey Draft Report, Contract Year 2012, 28.

[10] Texas Medicaid STAR Program Adult Member Survey Report, Contract Year 2012, 4.

[11] David Margolius, Thomas Bodenheimer; Redesigning After-Hours Primary Care. Annals of Internal Medicine. 2011 Jul;155(2):131-132. Available at http://annals.org/article.aspx?articleid=747046.

[12] Texas Medicaid STAR Program Adult Member Survey Report, Contract Year 2012, 4.

health, and acute care with long term services and supports. Amendment requests, for an effective date of September 1, 2014, include:

- Implementation of the STAR+PLUS MRSA expansion;
- The provision of mental health targeted case management and mental health rehabilitation services through Medicaid MCOs (except in the NorthSTAR service area);
- Carving nursing facility services into STAR+PLUS, with the goal of delaying the transition from the home to a nursing facility for many, reducing hospitalizations for clients already residing in a nursing facility, and increasing quality of care;
- Adding supported employment and employment assistance services to the STAR+PLUS HCBS program; and,
- Providing acute care services for members receiving services through a community-based intermediate care facility for individuals with intellectual disabilities or a related condition (ICF/IID), or an ICF/IID waiver through STAR+PLUS.

HHSC has also requested the addition of cognitive rehabilitation therapy as an available service in the STAR+PLUS home and community based services waiver, effective March 1, 2014.

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 STC 40(c), regarding dental stakeholder meetings.

1. 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 2013 D4 Demonstration period (July - September 2013), MAXIMUS sent 267,480 enrollment mailings to potential STAR and STAR+PLUS clients, and 172,194 mailings to potential Dental Program clients. MAXIMUS field staff completed 22,649 home visit attempts for these programs, and 73,485 phone calls attempts. Additionally, MAXIMUS completed 5,457 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; and
- how to get transportation through the State's Medical Transportation Program.

2. **Dental Stakeholder Meeting**

HHSC held a Dental Stakeholder Meeting on July 31, 2013, in Austin, Texas. The meeting was open to the public, and participants also had the opportunity to participate via webinar. Representatives from the HHSC, the two dental plans, as well as members of the Texas Dental Association attended the meeting in person. Approximately 10 dentists and orthodontists from various parts of Texas also attended the meeting in person, and there were approximately 86 webinar participants.

Prior to the meeting, stakeholders were asked to send questions to the State's dental stakeholder email box: DentalStakeholderMeeting@hhsc.state.tx.us. During the meeting, the state staff presented information and responded to stakeholder questions on various topics, including: main dental home changes, provider credentialing, and rules surrounding verbal enticements and solicitation of members. HHSC staff also presented an overview of the upcoming 2014 program quality initiatives. The presentation is available in the attachments to this report.

IV. COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA

During 2013 SFQ4, the State did not identify any significant issues regarding the collection or verification of enrollment or encounter 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 2013 SFQ4. 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 ON OPERATIONAL ISSUES IDENTIFIED IN THE PRIOR QUARTER

HHSC has 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.

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) affirmed the trial court's decision on June 27, 2013. There was no appeal, and the Court's mandate issued on September 12, 2013.

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. The case against Secretary Sebelius was dismissed by joint stipulation, without prejudice, filed January 2, 2013.

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 (Austin). Briefs were filed in August (by Appellant) and September (by the State/Appellee). The Court of Appeals affirmed the trial court's decision on July 12, 2013. On August 26, 2013, Plaintiff / Appellant filed a petition for review with the Texas Supreme Court. On November 22, 2013, the Texas Supreme Court denied a petition for review.

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, and the case remains dormant but pending. OAG has filed a general denial and a plea to the jurisdiction.

C. NEW ISSUES

HHSC has identified any ongoing issues in the relevant subject matter sections of this report. There were no issues outside of the general categories typically reported and HHSC does not anticipate any significant issues or activities in the near future that affect healthcare delivery.

D. BIANNUAL CLAIMS SUMMARY

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

1. Claims Adjudication

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

- 98 percent must be adjudicated within 30 days;
- 98 percent of appealed claims must be adjudicated within 30 days; and
- 99 percent must be adjudicated within 90 days.

Attachment P is a summary of the health and dental plans' 2013 SFQ3 and SFQ4 claims adjudication results. For these quarters, STAR and STAR+PLUS MCOs reported results for acute care, behavioral health, and vision services claims. STAR+PLUS MCOs also reported results for long-term care claims. Dental plans reported results for all dental claims in 2013 SFQ3 and SFQ4. Data from Molina for SFQ4 was not available in time to include in this report, due to erroneous reporting and unresolved systems issues at Molina.

As a whole, the STAR plans experienced a number of difficulties resolving claims in SFQ3 for acute care, behavioral health, vision, and to a lesser extent pharmacy claims. However, for behavioral health claims, most MCOs missed the benchmarks due to a handful of unresolved claims among a small pool of total claims.

Consistent with prior experiences in 2013, FirstCare had the most deficiencies—missing almost every single benchmark in both SFQ3 and SFQ4. FirstCare implemented a new claims system in

SFQ1 and is still experiencing system issues. The MCO had previously expected to resolve claims issues towards the end of SFQ3, but did not show substantial improvement for all indicators by SFQ4. FirstCare remains under a corrective action plan and is subject to liquidated damages. Also consistent with prior experience, Molina had significant failures to meet the performance benchmarks. Rates of timely adjudication of appeals within 30 days fell below 20 percent in most service areas. Outside of these 2 MCOs, most plans that missed the performance benchmarks resolved at least 90 percent of claims in a timely manner in SFQ3.

By SFQ4, however, most MCOs improved performance significantly across measures in STAR (with Molina unreported in SFQ4). In SFQ4, aside from FirstCare, there were only 6 among 342 possible instances where MCOs missed a claims resolution benchmark.

Trends in the STAR+PLUS program were similar. In SFQ3, the STAR+PLUS plans experienced difficulties meeting the standard for the timely adjudication of appealed acute care, behavioral health, and long-term care claims, but by SFQ4 there were only 2 instances of plans failing to hit the benchmark (among 240 possible, with Molina unreported).

Finally, in 2013 SFQ3 and SFQ4, both dental plans exceeded the State's claim adjudication standards for clean claims adjudicated within 30 days and 90 days.

>   2. *Provider Fraud and Abuse*

The State's managed care contracts require health and dental plans to form special investigative units that refer suspected cases of fraud, waste, or abuse to the HHSC Office of Inspector General (OIG). Attachment R is a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period, 2013 SFQ3-4.

In SFQ3 and SFQ4, health plans forwarded 31 suspected cases of fraud, waste, or abuse to the OIG. A majority of these referrals related to billing, including non-appropriate billing, billing for services not rendered, or billing unnecessary services. The most common outcome was a return to the MCO for the determination of appropriate action (12 referrals) or the launch of a full scale investigation (9 referrals). Dental plans forwarded 32 suspected cases of fraud, waste, or abuse to the OIG. Among the most common outcomes, six of these referrals were transferred to existing full scale cases, six were returned to the MCO for the determination of appropriate action, two resulted in full scale investigations, and two were referred to Medicare.

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 2013 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 2013 Q4.

VIII. MEMBER MONTH REPORTING

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

Figure 19: Eligible Member Month Participants

	STAR Program		STAR+PLUS Program	
	D&B	TANF Related	D&B	Aged & MR
Jul-13	51,862	2,506,562	182,423	226,423
Aug-13	51,553	2,465,214	179,934	227,816
Sept-13	52,296	2,474,877	183,383	226,233

The tables below address the quarterly reporting requirements in STC 65, regarding member months.

Figure 20: Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Jul 2013)	Month 2 (Aug 2013)	Month 3 (Sept 2013)	Total for Quarter Ending 09/13
Adults	254,178	252,577	253,618	760,374
Children	2,549,461	2,538,900	2,539,004	7,627,364
AMR	292,366	292,773	293,430	878,569
Disabled	424,324	424,007	426,619	1,274,950

Figure 21: Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Jul 2013)	Month 2 (Aug 2013)	Month 3 (Sept 2013)	Total for Quarter Ending 09/13
AMR in MRSA	76,347	76,529	76,576	229,452
Foster Care	33,645	33,868	33,897	101,411
Medically Needy	289	307	307	903
Qualified Aliens	18,544	18,281	18,136	54,961

IX. CONSUMER ISSUES

This section addresses complaints and calls to the HHSC help desk received in 2013 SFQ3, 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.

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 Children's Health Insurance Program (CHIP) calls for reporting purposes.

In the first three fiscal quarters of 2013, member and provider calls decreased. In SFQ4, total member calls continued this trend, decreasing by 3.66 percent. Provider calls also decreased in SFQ4 by 6.98 percent. Total calls to the health plans' behavioral health crisis lines decreased by 17.18 percent.

In handling these calls, all plans except one met all hotline performance benchmarks in 2013 SFQ4. Based on a very low volume of calls to its behavioral health crisis hotline, Sendero missed the answered by the fourth ring standard. Otherwise, all standards were met by all plans:

- 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; and
- ≤ 2 minute average hold time.

In the Dental program, member call volumes increased by 1.4 percent at DentaQuest compared to SFQ3. DentaQuest missed the standard for member calls answered by a live person for a second time in the year. In SFQ4, performance declined, with only 66 percent of member calls answered by a live person within 30 seconds. DentaQuest providers also experienced significant wait times for a portion of the fourth fiscal quarter, despite a decrease in total provider calls in SFQ4, and the call abandonment rate rose from three percent in SFQ3 to nine percent in SFQ4, exceeding the seven percent or less standard. DentaQuest has been placed on a corrective action plan to address these issues.

MCNA, in contrast, met all performance standards. Member calls declined by 11 percent, and provider calls declined by 4.56 percent in SFQ4.

B. 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 require 98 percent compliance with this benchmark.

1. STAR and STAR+PLUS

STAR plans collectively reported 409 member complaints, 1,090 member appeals, and 284 provider complaints in 2013 SFQ4. The number of member complaints in each STAR service

area was relatively stable. Member appeals to MCOs remained stable as well, with Superior's increase of approximately 250 member appeals from SFQ2 to SFQ3 carrying through to SFQ4. Provider complaints declined, primarily due to a return to prior volumes within Superior service areas.

Figure 22: Complaints and Appeals Received by STAR Plans
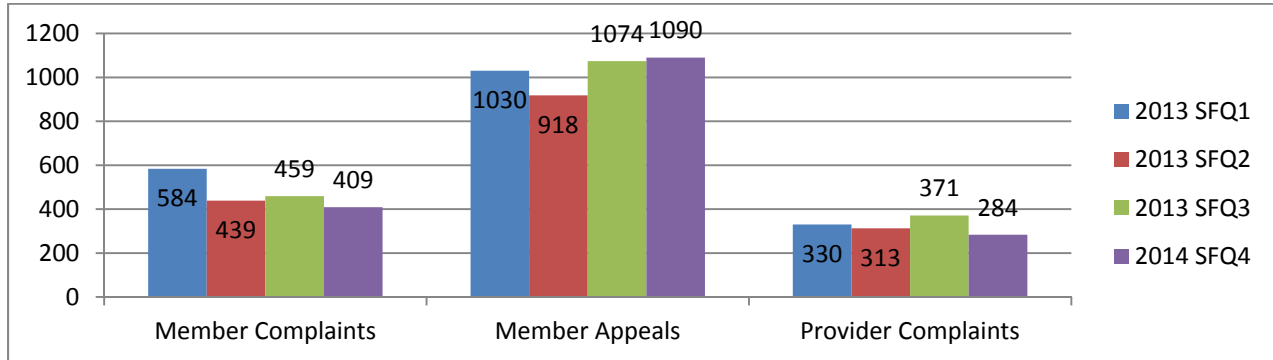
In STAR+PLUS, complaints and appeals generally decreased in 2013 SFQ4. Total member complaints, however, increased due to a spike in complaints in the United Harris network, where member complaints increased from 53 to 140. This spike was only partially offset by a decline in the Healthspring Hidalgo network (111 to 65 member complaints). Otherwise, member complaint volumes were generally consistent with SFQ3 volumes. Member appeals returned to a normal volume after the number of member appeals in the Superior Hidalgo network declined from 620 in SFQ3 to 202 in SFQ4. Molina Hidalgo appeals also declined significantly, dropping from 214 to 132. Even after these substantial declines, however, member appeals from the Hidalgo service area composed a much larger percentage of total member appeals than would be expected based on total enrollment market share in the STAR+PLUS program. The MCOs in the Hidalgo service area experienced 28 percent of all member appeals with only 18 percent of STAR+PLUS enrollment.

**Figure 23: Complaints and Appeals Received by STAR+PLUS Plans**
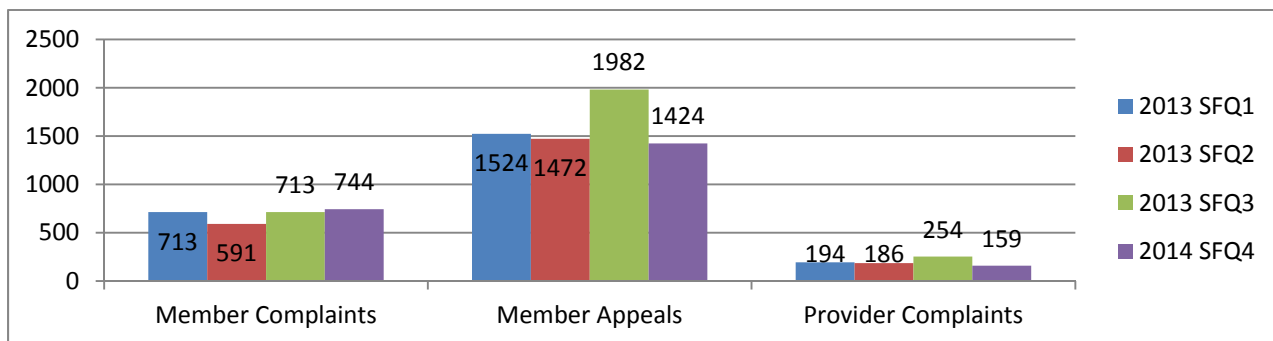
Member appeals were also disproportionately distributed by MCO, with 49 percent of member appeals in SFQ4 coming from members in Superior service areas, though the MCO represented

only 29 percent of enrollment in STAR+PLUS. This did represent a decline from SFQ3, when Superior had 60 percent of all member appeals compared to 26 percent of enrollment, but in SFQ4 the MCO represented the single greatest outlier in terms of member appeals relative to market share.

In both STAR and STAR+PLUS, in fact, Superior's share of complaints and appeals greatly exceeded market share. Figure 24 shows the percentage of member complaints and appeals by MCO, with a vertical black line drawn showing the MCOs market share in both STAR and STAR+PLUS. Superior had 46 percent of member appeals and complaints in STAR and STAR+PLUS with 26.51 percent of the STAR and STAR+PLUS market share.

Figure 24: MCO share of member complaints and appeals in STAR & STAR+PLUS
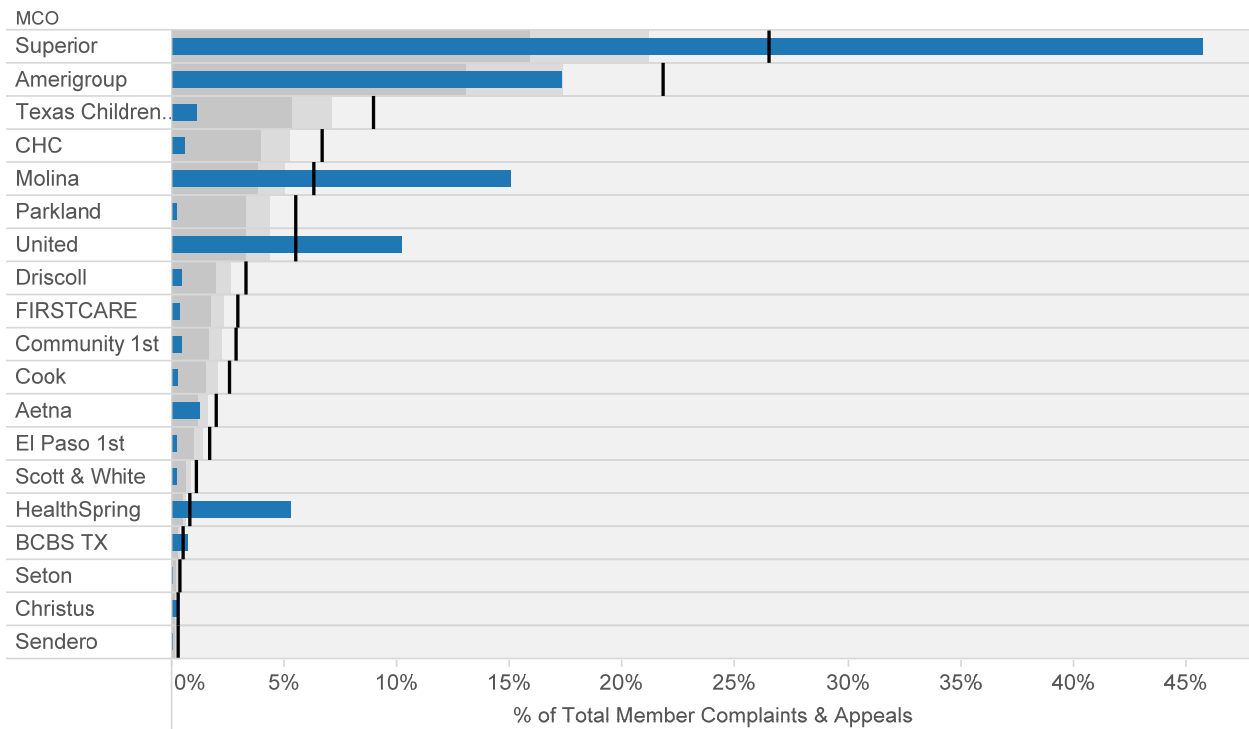
Superior's Bexar, Dallas, Hidalgo and the rural service areas were the service areas where their share of member appeals greatly exceeded the proportion of enrollment relative to total enrollment in STAR and STAR+PLUS. In all of these service areas, member appeals were almost exclusively due to medical benefit denials or limitations.

Molina and Healthspring also had significantly higher than expected complaint volumes. HealthSpring, which is a STAR+PLUS only MCO, had 8.9 percent of complaints in STAR+PLUS with 6 percent of the STAR+PLUS market share. Molina, in contrast, had a lower than expected share of complaints in STAR+PLUS, but showed a high ratio of complaints in Figure 24 due to its STAR Dallas and Hidalgo service areas.

United performed near expectations in both STAR and STAR+PLUS, with a share of complaints exceeding market share by only one percent in STAR+PLUS, but the chart above shows a higher mismatch across STAR and STAR+PLUS due to the disproportionate impact of complaints in STAR+PLUS on its total share of complaints in STAR and STAR+PLUS.

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 prior authorization denials. Member appeals most commonly involved the denial or limitation of a benefit; dissatisfaction with plan administration; and untimely responses to authorization requests. Providers generally complained about utilization review; plan administration; and claims processing, billing, or denials.

A majority of the health plans met the State's 98 percent benchmarks for resolving complaints and appeals within 30 days. In SFQ4, the 98 percent standards were met by:

- 45 of 45 STAR and 21 of 24 STAR+PLUS MCO service areas for member complaints;
- 44 STAR and 20 STAR+PLUS service areas for member appeals; and
- 45 STAR and 22 STAR+PLUS service areas for provider complaints.

In STAR+PLUS, missed benchmarks occurred primarily in the United networks.

Figure 25 shows the average timely resolution of complaints and appeals in 2013, calculated using each MCO specific service area percentage rate as the basis to calculate the average.

Figure 25: STAR and STAR+PLUS Program Averages for Timely Resolution of Complaints and Appeals – 2013
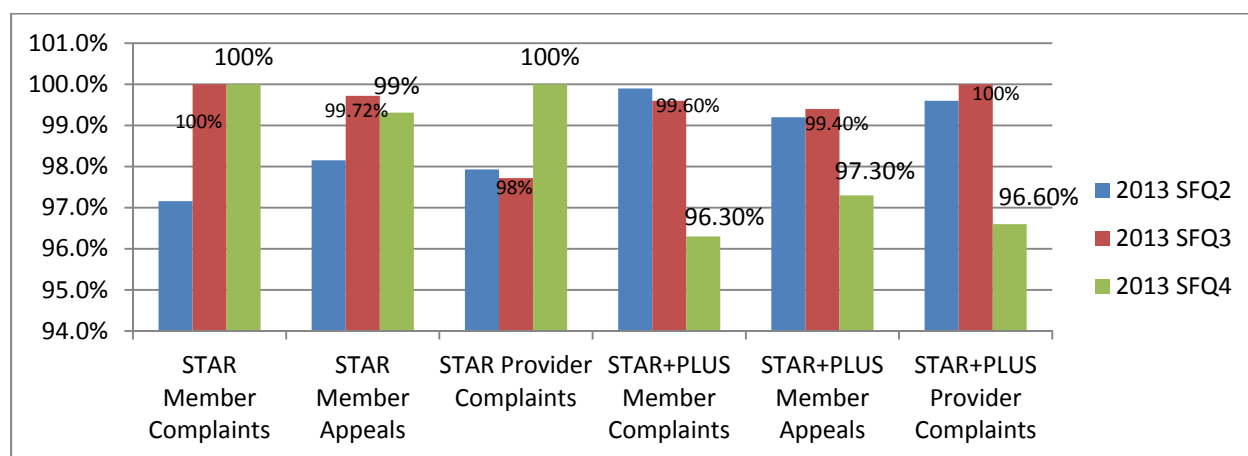
The State will continue to monitor compliance percentages for performance improvements.

2. *Dental Program*

In SFQ4 dental member complaints increased, while both member appeals and provider complaints decreased. Complaints and appeals are reported only in aggregate for each statewide dental plan, so any fluctuations within service areas would not be captured by HHSC. Because each health plan has over one million members enrolled across the state, the changes in complaints and appeals represent a very small fluctuation as a percentage of enrolled members (less than a tenth of one percent) that may be expected between fiscal quarters as utilization patterns change.

Figure 26: Complaints and Appeals Received by Dental Plans

The most common member complaints to the dental plans involved either (1) dissatisfaction with the quality of care provided by a treating dental provider, or (2) access to or availability of services. Member appeals primarily related to dental plan's utilization review or management, such as the denial of prior authorization requests. Providers generally complained about plan administration and claims processing.
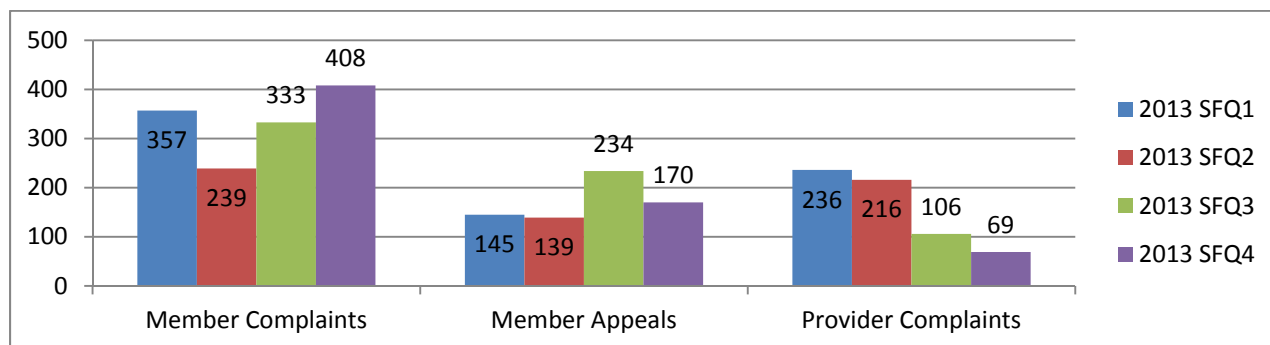
MCNA met or exceeded all performance standards for the timely resolution of complaints and appeals in SFQ3. DentaQuest, however, failed to meet all relevant benchmarks for the timely resolution of complaints. While the timely resolution of member complaints improved significantly, increasing from 55 percent within 30 days to 89 percent, DentaQuest still fell short of the 98 percent benchmark. The resolution of member appeals improved as well. In SFQ4, DentaQuest resolved 96 percent of member appeals within 30 days, compared to 90 percent in SFQ3. The timely resolution of provider complaints declined, however, dropping from 100 percent to 95 percent.

C. 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 HHSC staff and through the State's helpline. After investigating each complaint, State staff determines whether or not it is justified.

1. STAR and STAR+PLUS

In STAR, the number of member, helpline, and provider complaints received by HSSC remained stable throughout the year. In SFQ4, the State received 19 member, 272 provider, and 104 helpline complaints.

Figure 27: Complaints to the State Regarding STAR
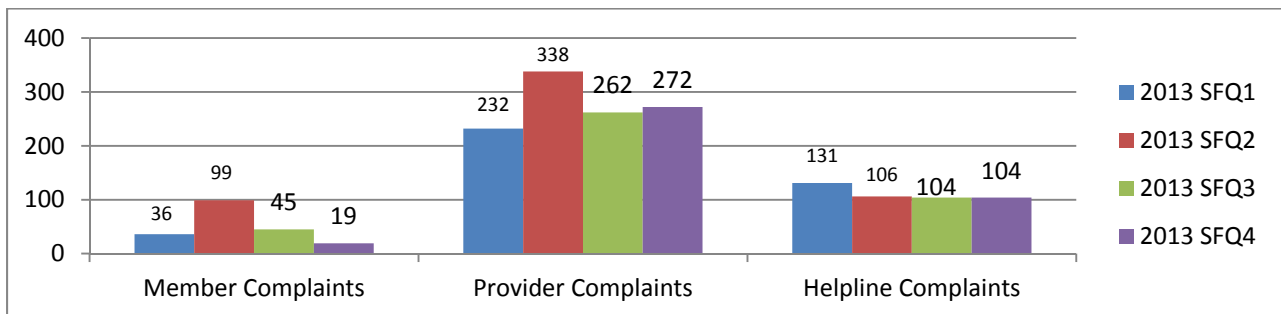
In STAR+PLUS, the number of complaints also remained relatively stable in SFQ4. The State received 87 member, 113 provider, and 190 helpline complaints in 2013 SFQ4 for STAR+PLUS.

Figure 28: Complaints to the State Regarding STAR+PLUS
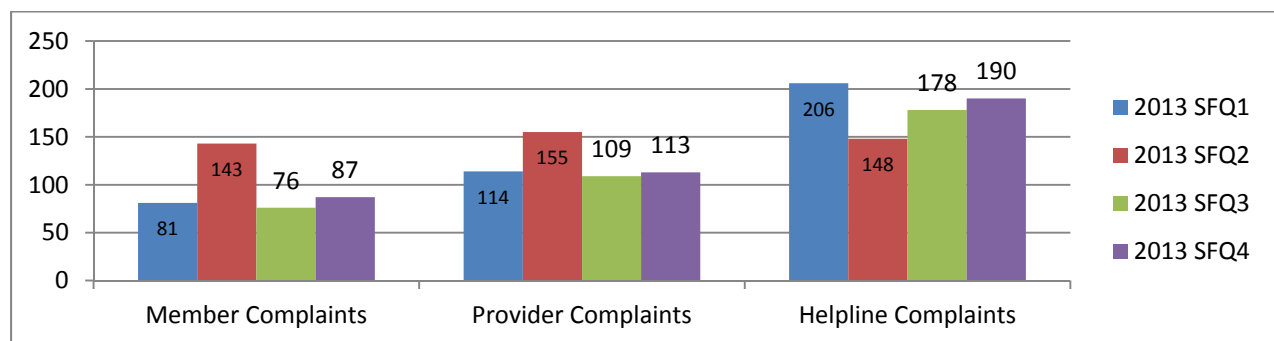
In both STAR and STAR+PLUS, most provider complaints (72 percent) received by the state were related to claims issues, commonly due to claims denials. Approximately 40 percent of provider complaints (149 of 387) were substantiated by HHSC in SFQ4.

The most common member complaint pertained to benefit denials or access to care (35 percent), with access to long term care services or DME representing the most common access complaint (16 percent of all member complaints). Access to long term care services or DME also represented 2 of the most common justified complaint types (8 and 5 of 89 justified member complaints). In total, HHSC found that 21.5 percent of member complaints were justified in SFQ4.

2. *Dental Program*

The number of member complaints, provider complaints, and helpline complaints in the dental program received by the state declined across categories in SFQ4, as shown in Figure 29.

Figure 29: Complaints to the State Regarding the Dental Program
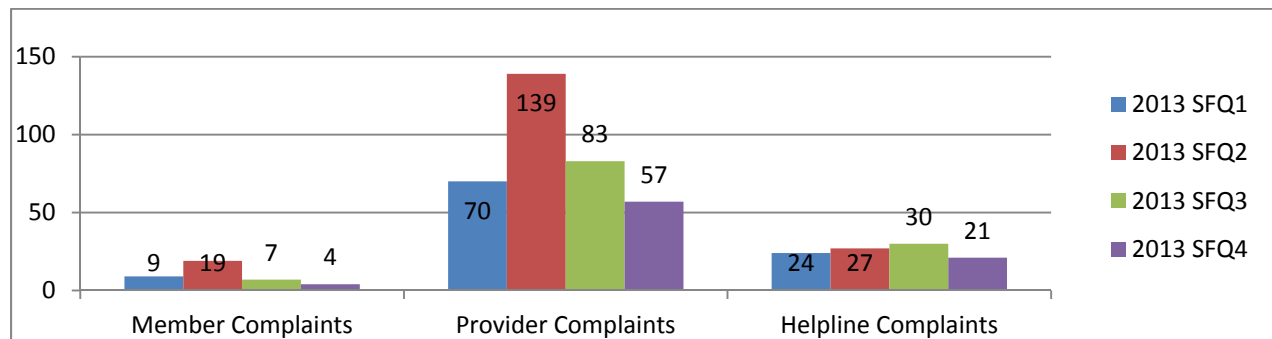
Of the four member complaints, one was justified in SFQ4. There were also 29 justified provider complaints, and 2 justified helpline complaints. The most common justified complaint related to claims denials.

X. QUALITY ASSURANCE/MONITORING ACTIVITY

A. GENERAL UPDATES

During the reporting period, HHSC continued to make progress on developing and refining Texas' managed care risk-based incentive program to focus on an incremental improvement approach. Metrics used for this initiative include goals set by legislative leadership, such as the reduction of potentially preventable events. The model under development will be implemented beginning in calendar year 2014 and will focus on rewarding MCOs based on attainment of a minimally acceptable performance level and incremental improvement. During the next fiscal quarter, HHSC will meet with MCO leadership to obtain feedback on the model and continue refinements prior to implementation.

During the fourth state fiscal quarter, HHSC applied a reduction to the capitation rate for MCOs based on performance of hospitals on potentially preventable readmissions. Capitation rates were adjusted for reductions effective September 1, 2013, based on hospital performance during fiscal year 2010. The revised capitation rate was calculated by factoring in an adjustment based on hospitals that had an actual to expected ratio of potentially preventable readmissions above 1.10, in accordance with the HHSC rules. In July, 2013, MCOs were provided a list of hospitals that received payment adjustments for fee-for-service claims effective May 2013.

As part of SB 1542 (83rd Legislature, 2013) HHSC is required to establish an internet website to provide information on quality initiatives and projects that are currently occurring at HHSC. The Medicaid quality website under development during this reporting period will serve as a central

location for the public and other stakeholders to access information related to Medicaid quality with the aim of promoting transparency. The intent of this website is to consolidate and increase accessibility of information that exists in various locations on the HHSC website and to provide additional information related to Medicaid quality.

During the reporting period, HHSC approved provider incentive programs in both Medicaid and CHIP dental maintenance organizations (DMOs). The approved programs reward in-network providers for meeting prevention metrics. Both the incentive payments and administrative costs necessary to implement the provider incentive programs will be considered allowable expenses. HHSC has sent several rounds of clarification questions to both DMOs and has received subsequent feedback. HHSC is also beginning efforts to allow MCOs to implement provider incentive programs.

B. REPORT CARDS AND CAHPS® SURVEY RESULTS

As directed by Senate Bill. 7, 82nd Legislature, 1st Called Session, 2011, HHSC continued development of MCO report cards to help members of STAR, STAR+PLUS and CHIP identify and select a health plan. A separate report card has been 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 reports cards will be available to members on the HHSC website and included in the enrollment packets sent to all newly eligible members. The measures will be updated annually.

The EQRO completed surveys between May and December of 2013 for CHIP, STAR Adults, and STAR Children, and between May 2012 and September 2012 for STAR+PLUS using Consumer Assessment of Healthcare Providers and Systems (CAHPS®) questions. Measures from the CAHPS® surveys were risk-adjusted by Clinical Risk Group (CRG), poverty at the census tract level, and service area.

Following National Committee for Quality Assurance (NCQA) specifications, performance ratings are not reported for any plan code with fewer than 100 members in the denominator for a particular measure. For these plan codes, the rating is listed as "No rating".

Figure 30 shows the CAHPS® domains used in each program for the report cards and the distribution of ratings across the program.

Figure 30: Report Card Ratings on CAHPS® Related Questions

Plan	CAHPS® Survey Measure	Count of MCO Service Area Ratings			
		Below Average	Average	Above Average	Low Denominator
STAR Child	Getting Care Quickly		23	1	
	How Well Doctors Communicate		21	3	
	Health Plan Rating	2	17	5	
STAR Adult	Getting Care Quickly		19	1	4
	How Well Doctors Communicate		9		15
	Health Plan Rating	2	19	2	
STAR+PLUS	Getting Care Quickly		13	1	
	How Well Doctors Communicate	1	11	2	
	Getting Specialist Care	1	10	1	2
	CAHPS® Health Plan Rating	2	11	1	

HHSC and the EQRO have identified systematic differences between plan types in consumer ratings of plan satisfaction and are developing a research plan to explore the underlying dynamics.

The EQRO has also produced a draft version of the FY 2012 STAR Adult Member Survey report which offers a more in-depth analysis based on a full CAHPS survey. Surveys were conducted between February 2012 and August 2012 based on members aged 18 to 64 who were continuously enrolled between July 2011 and December 2011. The survey and report focused on the demographic and health characteristics of adults enrolled in STAR and their experiences and satisfaction across four domains of care:

- Access and timeliness of care;
- Patient-centered medical home;
- Care coordination; and,
- Health plan information and customer service.

According to the EQRO, positive findings of the report included:

- *Member Ratings*: Greater than half of survey respondents rated the service of their health care, personal doctor, specialist, and health plan as a 9 or 10 on a 10-point scale. Each rating met or surpassed the Medicaid national average.
- *Good access to special therapies:* Approximately two out of three members who needed special therapies said that it was usually or always easy to get the therapy they needed (62 percent). This rate exceeds the HHSC Dashboard standard of 47 percent.
- *Access to prescription medicines:* Approximately half of members reported that they got new prescription medicines or refilled a medication during the past 6 months (53 percent). Among these members, 84 percent reported that it was usually or always easy to get the medicine they needed from their health plan.
- *Shared decision-making:* Nearly four out of 5 members said that they were usually or always involved as much as they wanted in their health care (79 percent) and that they usually or always felt that it was easy to get their doctors to agree on how to manage their health care problems (79 percent).
- *Care coordination:* Nearly 2 out of 3 members reported that they had someone helping to coordinate their health care (61 percent). Among these members, a vast majority reported that they were satisfied or very satisfied with the assistance they received (93 percent).

Areas for improvement identified by the EQRO included:

- *Getting Care Quickly:* Seventy percent of members usually or always had positive experiences with *Getting Care Quickly*, which is lower than the national Medicaid rate of 81 percent for this measure.
- *Good Access to Routine Care*: Approximately two-thirds of members reported that they had good access to routine care (67 percent). This rate is lower than that of the HHSC Dashboard indicator (78 percent).
- *Office Wait:* Only about 1 in 5 members reported having no wait greater than 15 minutes before being taken to the exam room (21 percent). This rate is considerably lower than the HHSC Dashboard standard of 42 percent.

- *Getting Needed Care:* Sixty-six percent of members usually or always had positive experiences with *Getting Needed Care.* This percentage is considerably lower than the national Medicaid rate of 78 percent.
- *Having a personal doctor:* Sixty-eight percent of members reported that they had a personal doctor, which is lower than the national Medicaid average of 79 percent.
- *Emergency department utilization*: Thirty-eight percent of members visited the emergency department at least once in the past six months. Among these members, 70 percent said they did *not* contact their personal doctor before going to the emergency department. Lack of after-hours access to their personal doctor was one of the most important reasons why they did not contact their personal doctor.

D. QUALITY OF CARE REPORT

This section addresses STC 24(e) of the 1115 Waiver which requires annual reporting requirements regarding service utilization, in conjunction with the CAHPS survey results reported throughout this report and the utilization figures reported on the Children With Special Healthcare Needs report produced by the EQRO.

The Texas EQRO has drafted a preliminary Quality of Care report evaluating utilization and care provided between January 2012 and December 2012. HHSC is working with the EQRO to analyze the preliminary results and provide a more in-depth analysis of the results.

Key findings of the preliminary draft are presented below by program. Additional measures and trends can be found in the full draft report in Attachment T.

1. STAR+PLUS

Regarding diabetes care, the MCOs generally performed above the HHSC standards on diabetes related (HbA1c) *testing* but according to the EQRO, program and MCO-level performance on diabetes *control* was poor. Among STAR+PLUS members with diabetes, the rate of HbA1c control (28.3 percent) was lower than the HEDIS® 10th percentile. This comparison, however, is between individuals nationally with diabetes in Medicaid and the STAR+PLUS program and may result in comparing individuals with different average age, disability, and illness severities.

Regarding Antidepressant Medication management, rates of effective management on related sub-measures were high. The STAR+PLUS program-level rate for Effective Acute Phase Treatment (59.5 percent) was higher than the HEDIS® mean, and all MCOs performed above the HHSC standards. The program-level rate for Rates Effective Continuation Phase Treatment was above the HEDIS® 90th percentile.

2. STAR

Between the 2012 and 2013 quality of care report, an additional 795,306 members in the STAR program were captured in the analysis due to the inclusion of the Hidalgo and rural service areas in the STAR program as of March 2012. As a result, comparisons between the 2012 and 2013 report may be impacted by changes in demographics and the health status of members enrolled between reporting periods which have not yet been analyzed by the EQRO and HHSC.

According to the EQRO, performance on the HEDIS® Timeliness of Prenatal Care measure was poor. The Timeliness of Prenatal Care measure captures the percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment. Seven MCOs fell below the HEDIS® 10th percentile and all MCOs fell below the HHSC Dashboard standard except for El Paso First. Furthermore, between 2012 and 2013 the service area mean decreased from 83 percent to 74.4 percent.

In contrast, most plans performed above the HEDIS Well-Child Visits national mean for Adolescent Well-Care visits and above the HHSC dashboard standard for Well-Child visits in the first 15 months of life (6 or more well-child visits). Rates of low birth weight were largely below 6 per 100, but the rates of well-child visits in the third through sixth years of life were commonly below the HEDIS mean of 72 percent.

HHSC is currently evaluating strategies for improving outreach for preventative care.

E. EFFECTIVENESS OF THE QUALITY STRATEGY

The 1115 Transformation waiver was approved with a quality strategy taken from the predecessor 1915(c) STAR+PLUS program with the understanding that it would be replaced with an updated strategy that reflected the goals of the 1115 Transformation waiver. For the last two years, HHSC has been working to develop the revised strategy. The initial revised strategy was submitted to CMS in September 2012. Based on feedback received from CMS, a further revised strategy was submitted in July 2013 and CMS feedback was received in December 2013. HHSC has responded to these comments and updated the strategy to reflect anticipated changes to the program and has submitted a response in January 2014. Because HHSC does not yet have an approved final strategy for the 1115 Transformation waiver, an evaluation of the effectiveness of the strategy is not possible (Special Terms and Conditions number 27 of the 1115 Waiver). The following is a report on the implementation of the strategy currently found in Attachment D of the 1115 Transformation waiver document, organized by activity.

Figure 31: Quality Activities and Status

Activity	Status
Biannual Quality Forums	The 2013 Quality Forums were held in April and October. The first 2014 forum is scheduled to be held in April.

Evaluation of Initiatives	HHSC has implemented revisions to two initiatives.
	Until 2014, HHSC had a financial incentive program that consisted of two components, the At-Risk Program and the Quality Challenge Award. The At-Risk Program recouped up to five percent of a managed care organization's capitation rate based on failure to meet specified benchmarks. The Quality Challenge Award distributed funds, not to exceed five percent of the capitation rate, to managed care organizations that successfully met or exceeded certain benchmarks. This model had several shortcomings. The two components had different performance measures. As a result, a plan that had funds recouped for poor performance on the measures included in the At-Risk Program could earn those funds back through performance in the Quality Challenge Award component. Additionally, even after evolving over multiple years, the program tied large dollar amounts to measures with low volumes of data. This created potential for managed care organizations to experience significant financial losses based on a small amount of findings.

In January 2014, HHSC implemented the Pay-for-Quality Program. This program uses a single set of measures and provides financial incentives for incremental progress made by a managed care organization towards specified goals in comparison with that managed care organization's previous performance. The Pay-for Quality Program also differs from the previous program in that the at-risk percentage of a managed care organization's capitation rate is only four percent. Finally, payments made through this program are adjusted for managed care organization size. Evaluation of the Pay-for-Quality Program will be performed after sufficient time has passed to gauge success.

Managed care organizations are required to complete two annual performance improvement projects for each program they are contracted to provide (i.e., STAR, STAR+PLUS). Prior to 2014, HHSC assigned one project topic to the managed care organizations, and allowed the managed care organizations to choose the second. There were challenges |

	with some of the topics chosen by the managed care organizations. First, often the target population for the performance improvement project was not large enough. Second, the topic selected was not always one with significant improvement opportunities. Therefore, beginning with the 2014 projects, HHSC is assigning both topics. In response to legislative direction, beginning with the 2015 projects, managed care organizations will also be required to conduct one performance improvement project per program in collaboration with other managed care organizations in their service area.
External Quality Review Organization Contract Status	HHSC continues to contract with the Institute for Child Health Policy to conduct external quality review work. The current contract extends until August 31, 2014. HHSC is currently engaged in a procurement process to solicit proposals for a new contract to be executed in December 2015.
Quality of Care Reports	To streamline the external quality review organization reporting process, HHSC has consolidated some reports, including the quality of care reports previously provided by program. Beginning with the 2013 report, the medical and behavioral managed care Medicaid programs will be combined into a single report. The 2013 report is currently being reviewed by HHSC.
Quarterly Data Collection	Health Plan Management continues to collect quarterly data on administrative and financial measures.
Long-Term Services and Supports Report	The Institute for Child Health Policy conducted a study of the home and community-based long-term services and supports component of the 1115 Transformation waiver. The measurement period for this study was September 2010 through October 2012. HHSC is currently in the process of reviewing the report and expects it to be finalized in early 2014.

Develop Data Collection Methodologies	This activity was part of the STAR+PLUS 1915(c) waiver application. The measures that were included in the 1915(c) waiver were not nationally validated and reported measures with existing methodologies; therefore, HHSC was responsible for developing methodologies. The EQRO collects data using the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®), the Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs)/Prevention Quality Indicators (PQIs), 3M Software for Potentially Preventable Events, and Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys for the 1115 Transformation waiver, including the population served through the component that was formerly a 1915(c) waiver. The measures in these tools include nationally accepted data sources and specifications. HHSC has been working to develop revised long-term services and supports measures. The anticipated implementation date of the new set of measures is September 1, 2014. At that time, all measures used for the 1115 Transformation waiver will have established data collection methodologies in place.
Begin Phased Data Collection	The Interim Quality Improvement Strategy is based on the long-term services and supports measures in the STAR+PLUS 1915(c) application. Data collection, reporting, and analysis on non-long-term services and supports measures continue to be performed by the external quality review organization in all applicable service areas in the state. The anticipated implementation date of the new set of long-term services and supports measures is September 1, 2014. It has not yet been determined whether that implementation will need to include a phased-in approach.
Trending, Prioritizing, and Implementing System Improvements	HHSC is in the process of reviewing and revising internal processes related to the quality strategy. The goal of this exercise is to allow for meaningful implementation of recommended interventions in need areas, and to create a structure for evaluating the success of those interventions.

Implement Waiver Design Changes and have a Fully Operational Strategy	The 1115 Transformation waiver was approved with a quality strategy taken from the 1915(c) STAR+PLUS program with the understanding that it would be replaced with an updated strategy that reflected the goals of the 1115 Transformation waiver. For the last two years, HHSC has been working to develop that revised strategy. A strategy was submitted to CMS in September 2012. Based on feedback received from CMS, a further revised strategy was submitted in July 2013; CMS feedback was received in December 2013. After consideration, HHSC has developed an updated strategy that will be submitted to CMS in January 2014. If approved, this strategy will become operational during calendar year 2014.
Provide Executive Management with Recommendations for Program Improvement	The HHSC Medicaid/CHIP Division's Program Management section facilitates cross-departmental bi-weekly meetings with executive management to discuss quality-related issues.

XI. DEMONSTRATION EVALUATION

This section provides a summary of evaluation activities in Q4 and Demonstration Year (DY) 2.

A. Overview of Evaluation

This quarterly and annual report reflects evaluation activities from October 1, 2012, through September 30, 2013.

The Healthcare Transformation and Quality Improvement Program Demonstration Waiver (Program) includes two interventions:

Intervention I: The expansion of the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, creating a new children's dental program, while carving-in prescription drug benefits; and

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

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

This report identifies:

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

B. Summary of Evaluation Activities Related to the Quarterly

1. HHSC SDS Evaluation staff attended project meetings and monthly CMS calls.
2. HHSC SDS and Texas A&M attended bi-monthly meetings and continued discussions regarding evaluation methodologies, roles and responsibilities, and case study site selections.
3. HHSC SDS and Texas A&M updated the Executive Waiver Advisory Committee on the evaluation methodology and goals in Austin, TX on July 11, 2013.
4. HHSC SDS met and established semi-monthly meetings with Meadows Foundation via TriWest representative, Andrew Keller, and the Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin School of Social Work (Molly Lopez and Stacey Manser). TIEMH staff and TriWest are developing a database summarizing DSRIP-funded behavioral health projects.
5. HHSC SDS met with UT Houston PhD student, Adele Semann and her advisor, Stephen Linder to discuss student's possible contribution to the evaluation.
6. HHSC SDS hired an additional evaluator. The biographical sketch of the new evaluator is included in this report.
7. Texas A&M refined its detailed evaluation plan per HHSC SDS feedback. HHSC submitted the detailed evaluation plan to CMS for review.
8. HHSC SDS initiated meetings 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.
9. HHSC SDS submitted to CMS a white paper that describes procedures to submit a proposal for potential evaluation collaborators interested in the evaluation.
10. HHSC SDS initiated an Evaluation Workgroup. The workgroup consists of HHSC evaluation and program staff and external evaluators to discuss evaluation activities.

Intervention I

1. CMS and HHSC Waiver team requested a description of how the evaluation design will be modified to incorporate three amendment provisions which deal with 1) income eligibility changes to Medicaid/CHIP children ages 6 through 18 with incomes from 100 – 133 percent of the Federal Poverty Level, 2) former foster care youth (individuals who aged out of foster care at 18 years or older) up to the age of 26 (July 19, 2013), and 3) removing policy that allows a managed care organization to request disenrollment for beneficiaries who are dependent on a ventilator or who have been diagnosed with End State Renal Disease (July 29, 2013).
2. HHSC SDS hired an additional evaluator. The biographical sketch of the new evaluator is included below.

Angie Cummings, DrPH, Evaluator

Angie Cummings is a Research Specialist with Texas Health and Human Services Commission. She earned her DrPH in Community Health Practice from The University of Texas School of Public Health and her MSPH in Global Communicable Disease from the University of South Florida. Her research interests include maternal and child health, global health, and health disparities. She is experienced in survey research and participatory research methods (study design through analysis and reporting), and aims to apply mixed methods approaches in research and evaluation studies. Prior to studying public health, she was a teacher and earned a MEd from Framingham State College and a BS in Math/Science Elementary Education from Texas Christian University.

3. HHSC SDS initiated an Evaluation Workgroup meeting in Austin, TX on September 19th with representatives from HHSC Transformation Waiver Operations (Ardas Khalsa), HHSC Healthcare Quality (Matthew Ferrara, Katherine Layman), HHSC Medicaid/CHIP (Bill Rago, Kyle McKay), HHSC SDS Evaluation (Laura Jordan, Sarah Roper-Coleman, Angie Cummings, Tenaya Sunbury), Texas A&M (Rebecca Wells, Sean Gregory, Hye-Chung Kum) and TriWest (Andrew Keller, Jim Zahniser), to discuss on-going evaluation activities.
4. HHSC SDS Evaluation staff continued to identify and collect baseline data for Intervention I.
5. HHSC SDS Evaluation staff continued to finalize an Intervention I evaluation plan protocol which includes stratification methodology.

Intervention II

Overall:

1. HHSC and Texas A&M received the fully executed contract dated July 08, 2013.
2. Texas A&M Institutional Review Board (IRB): approval for case study (evaluation goals 6-8), began drafting additional IRB submissions (evaluation goals 9-11).
3. Texas A&M presented on Intervention II to the Evaluation Workgroup in Austin, TX, on September 19, 2013.

Evaluation Goal 5:

4. Texas A&M hired its fourth budgeted doctoral student to assist with data management and statistical analysis for Evaluation Goal 5. Affan Ghaffari earned an MPH from Boston University, and was selected for the A&M team based on his strong background in health policy and management and data analysis skills.
5. Texas A&M prepared the combined analytical dataset (Area Resource Files (ARF), Department of State Health Services/Texas Hospital Association (DSHS/THA), and Health and Human Services Commission (HHSC) Rate Analysis data) using 2011 and 2012 data.

Evaluation Goal 6-8:

6. Texas A&M negotiated fees for use of proprietary instruments (SF-8 and Relational Coordination) and verified that other instruments are in the public domain.
7. Texas A&M continued refinement and initiated pilot testing of the instruments for the case study.
8. Texas A&M, with HHSC SDS co-investigators, identified 10 concurrent comparison emergency departments for the case study data collection.
9. Texas A&M initiated contact with the identified sites, recruiting their participation in the case study. Scheduling of Fall 2013 site visits was initiated.
10. Texas A&M trained the case study team on site visit protocol and instrument use.

Evaluation Goal 9:

11. Texas A&M drafted and began piloting the interorganizational network (ION) survey instrument.
12. Texas A&M, with HHSC SDS, contacted RHP anchors to identify appropriate contacts at RHP member organizations for the ION survey.

Evaluation Goal 10-11:

13. Texas A&M began initial development of the stakeholder survey and continued to develop the sample roster.
14. Texas A&M, with HHSC SDS, contacted RHP anchors to identify contacts at RHP member organizations for the RHP member survey.

Challenges or Issues Encountered

No significant challenges were encountered in the last quarter.

C. **Summary of Evaluation Activities Related to the Annual**

1. Texas Health and Human Services Commission (HHSC) Evaluation attended regular meetings with various stakeholders within and outside of HHSC, including the HHSC Waiver team; Centers for Medicaid and Medicare Services (CMS); the Executive Waiver Advisory Committee; Texas A&M (evaluation partner); the Evaluation Workgroup; Meadows Foundation, The University of Texas School of Social Work, and Tri West; The University of Texas LBJ School of Public Affairs; Regional Health Partnership (RHP) anchor calls; and a student and advisor from The University of Texas School of Public Health (see Attachment X – Evaluation Meetings with External Stakeholders).
2. HHSC Evaluation initiated and engaged in meetings with HHSC Waiver team. The purpose of these meetings was to discuss ongoing evaluation activities, data access issues, roles/responsibilities of learning collaborative, and possible external evaluation partners.
3. HHSC Evaluation initiated and engaged in meetings with HHSC Rate Analysis team. The purpose of these meetings was to discuss payment structures for uncompensated care under the waiver and data requests for the evaluation.
4. HHSC Evaluation participated in bi-monthly RHP anchor calls and provided evaluation relevant information to the anchors when requested.
5. HHSC Evaluation posted a white paper describing procedures to submit a proposal for potential evaluation collaborators interested in the evaluation and is currently fielding requests to participate.
6. HHSC Evaluation hired an additional evaluator and currently has postings for one more evaluator and a program specialist.
7. The evaluation plan required by STCs 68 and 69 was approved by CMS.
8. Quarterly evaluation reports were submitted to CMS detailing evaluation accomplishments throughout the year.
9. An abstract was submitted and accepted for an oral presentation at the American Evaluation Association Conference. The presentation will occur in DY3 - presenters will include two HHSC Evaluation and one Texas A&M evaluation team members.

Intervention I

1. HHSC SDS hired an additional evaluator and has posted the positions for one more evaluator and a program specialist.
2. The evaluation plan was approved by CMS.

3. HHSC Evaluation continued to finalize an Intervention I evaluation plan protocol which includes stratification methodology.
4. HHSC Evaluation will include process measures in DY4 and DY5 to evaluate the implementation of three amendment provisions to the Program.
5. Baseline data collection ongoing.

Intervention II

Overall:

1. HHSC Evaluation and Texas A&M received the fully executed contract dated July 08, 2013.
2. HHSC Evaluation provided CMS a copy of the detailed evaluation plan.
3. Texas A&M hired five doctoral students to assist with the Program evaluation.
4. The Texas A&M Institutional Review Board (IRB) exempted evaluation Goal 5 data as not entailing human subjects and approved protocols for the case study (evaluation Goals 6-8).

Evaluation Goal 5:

5. Texas A&M prepared the combined analytical dataset (Area Resource Files (ARF), Department of State Health Services/Texas Hospital Association (DSHS/THA), and Health and Human Services Commission (HHSC) Rate Analysis data) using 2011 and 2012 data.

Evaluation Goal 6-8:

6. Texas A&M, with HHSC Evaluation co-investigators, identified Project Area Option 2.9.1, care navigation to reduce emergency department use, as the focus of the case study evaluation.
7. Texas A&M negotiated fees for use of proprietary instruments (SF-8 and Relational Coordination) and verified that other instruments are in the public domain.
8. Texas A&M developed and pilot tested all instruments for the case study.
9. Texas A&M, with HHSC Evaluation co-investigators, identified 10 DSRIP project sites and 10 concurrent comparison emergency department sites for the case study.
10. The case study team was trained to ensure consistent data collection across all sites.
11. Texas A&M recruited identified sites and began conducting site visits.

Evaluation Goal 9:

12. Texas A&M drafted and pilot tested the interorganizational network (ION) survey instrument.

13. Texas A&M, with HHSC Evaluation, contacted RHP anchors to identify appropriate contacts at RHP member organizations for the ION survey.

Evaluation Goal 10-11:

14. Texas A&M began initial development of the stakeholder survey and continued to develop the sample roster.
15. Texas A&M, with HHSC Evaluation, contacted RHP anchors to identify contacts at RHP member organizations for the RHP member survey.

Challenges or Issues Encountered

No significant challenges were encountered in DY2.

D. Activities Planned in Next Quarter (October 1, 2013 through December 31, 2013)

1. HHSC Evaluation staff will attend project meetings and monthly CMS calls.
2. The evaluation staff from HHSC and Texas A&M will continue to meet semi-monthly to collaborate and provide feedback on each other's evaluations.
3. The evaluation staff from HHSC, TriWest, and UT Austin will continue to meet semi-monthly to collaborate and provide feedback on the behavioral health project database.
4. HHSC SDS Evaluation staff will present at the American Evaluators Association Conference being held at Washington D.C. from October 13 – 19, 2013.
5. HHSC SDS Evaluation staff will continue to identify additional external evaluation collaborators.

Intervention I

1. HHSC SDS Evaluation staff will continue to gather baseline data for Intervention I.
2. HHSC SDS Evaluation staff will continue to develop Intervention I evaluation plan protocol which includes stratification methodology for inclusion.

Intervention II

3. Texas A&M will finish preparation of the combined analytical dataset (ARF, DSHS/THA, and HHSC Rate Analysis data) using 2008-2012 data and will conduct preliminary analyses.
4. Texas A&M will finalize case study survey and ION survey instruments and initiate data collection.
5. Texas A&M will continue to negotiate secondary data releases with HHSC, prepare data, and conduct exploratory descriptive analysis.

6. Texas A&M will draft RHP member survey and submit to HHSC SDS team for review.

E. Activities Planned in Next Year (October 1, 2013 through September 30, 2014)

1. HHSC Evaluation staff will attend project meetings with various stakeholders and monthly CMS calls.
2. HHSC Evaluation and Texas A&M will continue to meet semi-monthly to collaborate and provide feedback on each other's evaluations.
3. HHSC Evaluation, TriWest, and The University of Texas School of Social Work will continue to meet semi-monthly to collaborate and provide feedback on the behavioral health project database.
4. HHSC Evaluation will continue to identify additional external evaluation collaborators.
5. HHSC Evaluation and Texas A&M will present at the American Evaluation Association Conference (October 2013).
6. HHSC Evaluation and Texas A&M plan to submit paper abstracts to several professional organizations. Possible organizations include Academy Health, American Public Health Association, American Evaluation Association, and the National Rural Public Health Association. HHSC Evaluation and Texas A&M also plan to begin drafting publication manuscripts on the Program.

Intervention I

1. HHSC Evaluation will continue to gather baseline data for Intervention I.
2. HHSC Evaluation will continue to develop Intervention I evaluation plan protocol which includes stratification methodology for inclusion.
3. HHSC Evaluation will hire an additional evaluator and a program specialist.

Intervention II

4. Texas A&M will finish preparation of the combined analytical dataset (ARF, DSHS/THA, and HHSC Rate Analysis data) using 2008-2012 data and will conduct preliminary analyses.
5. Texas A&M will draft the RHP member survey and submit to HHSC Evaluation for review.
6. Texas A&M will finalize the baseline primary data collection for the case study (evaluation Goals 6-8) and interorganizational network analysis (evaluation Goal 9), as well as collect the one and only round of primary data collection for evaluation Goals 10-11.
7. Texas A&M will continue to coordinate secondary data releases with HHSC, prepare data, and conduct exploratory descriptive analysis.

In Q4, HHSC completed review of 398 revised projects that were not initially approved by CMS and submitted them to CMS by August 22, 2013. CMS provided approval to all regions by September 10, 2013, except for 48 outstanding projects that will receive a final CMS determination in FFY2014 Q1. The projects that were not initially approved were not eligible for DY 2 semi-annual metrics reporting in August 2013. During Q4, HHSC worked with providers to update these projects to address non-quantifiable DY 2 goals and missing data sources to be eligible for October DY 2 reporting.

Based on CMS feedback, HHSC required providers to review and confirm or identify quantifiable patient impact (QPI) and Medicaid/low income uninsured impact for each project. Providers submitted QPI information to HHSC by July 23, 2013, for all projects. The QPI information was gathered to inform CMS and HHSC review of DY 4-5 project valuation. HHSC also incorporated the QPI information into DY 3-5 milestones as the basis for payment for the applicable QPI metrics.

In preparation for RHP reporting, HHSC began working with a vendor in Q4 to develop the DSRIP reporting system for DY 3-5. In DY 2, HHSC will use a manual process until the web-based system is implemented.

Preparing for and processing August DY 2 DSRIP reporting was a large focus of Q4. HHSC received August reporting from over 170 providers for over 600 Category 1 or 2 projects, over 700 Category 3 outcomes, and over 85 Category 4 hospital reports. Most metrics (over 81 percent) were approved for the August reporting period for an estimated $514 million in DSRIP payments out of a total of over $588 million that was reported and over $823 million that could have been reported. Actual payments will be dependent on available IGT and processed in FFY2014 Q1.

HHSC continued stakeholder communications through webinars, bi-weekly Anchor calls, Executive Waiver Committee meetings, and companion documents in Q4. Webinars were hosted on completion of the QPI spreadsheet on July 9, 2013, and completion of the August DY 2 reporting template on August 15, 2013. On July 11, 2013, HHSC presented to the Executive Waiver Committee the next steps for responding to CMS feedback, an overview of DY 2 reporting, and an update on unspent DSRIP funds. HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2014 Q1.

In Q4, HHSC continued to lay the foundation for DSRIP monitoring efforts to occur in DY 3-5. HHSC submitted to CMS the draft criteria for the mid-point assessment to be conducted by the end of DY 3, and CMS approved amendments to the PFM Protocol effective September 6, 2013, that will enable HHSC to use a small portion of funds from DSRIP IGT entities to fund the non-

federal share of HHSC DSRIP monitoring contract(s). HHSC plans to use a pre-approved Texas vendor list (TXMAS) to procure a vendor to support DSRIP monitoring. The target start date for this contract is Spring-Summer 2014.

A. Accomplishments

Major DSRIP Activities during Federal Fiscal Quarter 1/2013 (10/01/2012-12/31/2012)
During Q1, HHSC was focused on developing a process for plan review and completing a high level review of the 915 Pass 1 Category 1 and 2 projects submitted by November 16, 2012. By early December 2012, all RHPs received preliminary feedback on non-approvable projects to incorporate changes prior to full plan submission. HHSC also issued immediate guidance to RHPs about the next steps in the plan review process, common issues identified through the high level review, and summary information that HHSC requested providers add to the beginning of each project in the full RHP Plan submission.

By December 31, 2012, all RHPs had submitted complete RHP Plans including 1,335 Category 1 and 2 projects with a total DSRIP valuation for Categories 1, 2, 3, and 4 for DYs 2-5 of $9.9 billion. The plans include 224 hospital Performing Providers, 38 community mental health centers (CMHCs), 20 local health departments (LHDs), 18 physician practices, and 82 uncompensated care (UC) only hospitals. The most proposed Category 1 Project Areas included 1.1 – Expand primary care capacity with 202 projects and 1.9 – Expand specialty care capacity at 140 projects. The most proposed Category 2 Project Areas included 2.13 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting with 92 projects and 2.9 – Establish/expand a patient care navigation program with 82 projects.

HHSC provided targeted technical assistance sessions at the request of RHPs, hosted weekly Anchor calls, and held a webinar to offer providers guidance on plan development from HHSC quality experts.

Major DSRIP Activities during Federal Fiscal Quarter 2/2013 (01/01/2013-03/31/2013)
In Q2, HHSC provided feedback to all regions on the RHP Plans submitted by December 31, 2012 within the 30-day state review period. HHSC's formal feedback included non-approvable projects, projects flagged for valuation, technical review project issues, workbook mismatches with the plan narrative, and other technical feedback on Sections I-VII of the RHP Plan. RHPs were given 15 days to address HHSC's formal comments and could request a 15-day extension. Most regions requested an extension to respond to HHSC feedback. To clarify feedback, HHSC provided targeted technical assistance sessions at the request of RHPs, hosted bi-weekly Anchor calls, and issued guidance on project valuation and collaborations.

All regions submitted revised RHP Plans incorporating HHSC formal feedback by March 18, 2013. HHSC reviewed resubmitted plans for changes to address non-approvable projects feedback, projects that were flagged for valuation, technical issues, and remaining collaborating projects. After HHSC review, RHP Plans were submitted to CMS to begin the 45-day formal CMS review and initiate DY 1 DSRIP payments. In Q2, HHSC submitted 14 RHP Plans to CMS representing 734 Category 1 and 2 projects and Category 1-4 valuation of $4,682,024,711.

During Q2, HHSC also worked with CMS to update the Program Funding and Mechanics Protocol to clarify CMS feedback on RHP Plans. The changes included distinguishing CMS initial approval from full approval of RHP Plans; identifying required priority technical corrections; establishing a required standard target setting methodology for Category 3; expanding requirements on learning collaboratives; and adding a mid-point assessment of RHP Plans.

In preparation for RHP reporting, HHSC released a targeted procurement in Q2 to contract with a vendor to develop the DSRIP reporting system for DYs 3-5. In DY 2, HHSC will use a manual process until the web-based system is implemented.

Major DSRIP Activities during Federal Fiscal Quarter 3/2013 *(04/01/2013-06/30/2013)*
In Q3, all revised RHP Plans were reviewed by HHSC and submitted to CMS by April 12, 2013. CMS provided feedback to all regions within the 45-day formal review period. To clarify feedback, HHSC provided targeted technical assistance sessions at the request of RHPs, hosted bi-weekly Anchor calls, and issued guidance in companion documents. HHSC also presented a summary of CMS feedback and changes to the Program Funding and Mechanics Protocol at the May 2, 2013 Executive Waiver Committee meeting and through a public webinar held on May 7, 2013.

HHSC processed CMS feedback through four phases. Phase 1 included revisions to receive initial approval, to justify a higher than approved project value, and/or to adjust project value to an alternate, lower amount. Phase 2 required providers to review and confirm or identify the quantifiable patient impact (QPI) and Medicaid/low income uninsured impact for each project. Phase 3 included revisions to DY 2 milestones and metrics necessary to be eligible for DY 2 DSRIP payments. Phase 4 addressed priority technical corrections and Category 3 changes.

In Phase 1, HHSC created over 400 cover sheets with information specific to each project to guide providers' revisions. Phase 1 included projects initially approved, with an adjustment to project value; projects not initially approved; and projects with improvement milestones that overlap with improvement targets. RHPs were given 28 days to revise and resubmit Phase 1 projects or submit replacement projects. HHSC and CMS's goal was to complete processing and approval of Phase 1 revisions in Q4.

HHSC developed spreadsheets for reviewing Phase 2 information in Q3 for providers to verify or update QPI and Medicaid/low income uninsured impact in Q4. Phase 3 began in Q3 with HHSC

identification of non-quantifiable DY 2 goals and missing data sources. RHPs had two opportunities to review and revise issues to be eligible for DY 2 August reporting. A similar process for DY 2 October reporting took place in Q4. Phase 4 began in Q1 of federal fiscal year 2014.

In preparation for RHP reporting, HHSC contracted with a vendor in Q3 to develop the DSRIP reporting system for DYs 3-5. In DY 2, HHSC will use a manual process until the web-based system is implemented.

During Q3, HHSC proposed administrative rules to be adopted in Q4 to address the new requirements in the Program Funding and Mechanics Protocol including the mid-point assessment, regional learning collaboratives, and the standard target achievement level setting methodology for Category 3. HHSC also updated the DSRIP rules to include the proposed process for plan modifications to add new three-year projects for DY 3-5s.

Major DSRIP Activities during Federal Fiscal Quarter 4/2013 *(7/01/2013 - 9/30/2013)*
In Q4, HHSC completed review of 398 revised projects that were not initially approved by CMS and submitted them to CMS by August 22, 2013. CMS provided approval to all regions by September 10, 2013 except for 48 outstanding projects that will receive a final CMS determination in FFY2014 Q1. The projects that were not initially approved were not eligible for DY 2 semi-annual metrics reporting in August 2013. During Q4, HHSC worked with providers to update these projects to address non-quantifiable DY 2 goals and missing data sources to be eligible for October DY 2 reporting.

Based on CMS feedback, HHSC required providers to review and confirm or identify quantifiable patient impact (QPI) and Medicaid/low income uninsured impact for each project. Providers submitted QPI information to HHSC by July 23, 2013 for all projects. The QPI information was gathered to inform CMS and HHSC review of DY 4-5 project valuation. HHSC submitted preliminary QPI information to CMS in August 2013 and a final data set in September 2013. HHSC also incorporated the QPI information into DY 3-5 milestones as the basis for payment for the applicable QPI metrics.

In preparation for RHP reporting, HHSC began working with a vendor in Q4 to develop the DSRIP reporting system for DY 3-5. In DY 2, HHSC will use a manual process until the web-based system is implemented.

Preparing for and processing August DY 2 DSRIP reporting was a large focus of Q4. HHSC received August reporting from over 170 providers for over 600 Category 1 or 2 projects, over 700 Category 3 outcomes, and over 85 Category 4 hospital reports. Most metrics (over 81 percent) were approved for the August reporting period for an estimated $514 million in possible DSRIP payments out of a total of over $588 million that was reported and over $823 million that could have been reported. Actual payments will be dependent on available IGT and processed in FFY2014 Q1.

HHSC continued stakeholder communications through webinars, bi-weekly Anchor calls, Executive Waiver Committee meetings, and companion documents in Q4. Webinars were hosted on completion of the QPI spreadsheet on July 9, 2013 and completion of the August DY 2 reporting template on August 15, 2013. On July 11, 2013, HHSC presented to the Executive Waiver Committee the next steps for responding to CMS feedback, an overview of DY 2 reporting, and an update on unspent DSRIP funds. HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2014 Q1.

In Q4, HHSC continued to lay the foundation for DSRIP monitoring efforts to occur in DY 3-5. HHSC submitted to CMS the draft criteria for the mid-point assessment to be conducted by the end of DY 3, and CMS approved amendments to the PFM Protocol effective September 6, 2013, that will enable HHSC to use a small portion of funds from DSRIP IGT entities to fund the non-federal share of HHSC DSRIP monitoring contract(s). HHSC plans to use a pre-approved Texas vendor list (TXMAS) to procure a vendor to support DSRIP monitoring. The target start date for this contract is Spring-Summer 2014.

Other DSRIP Activities Initiated in DY2
In addition to the above activities outlined for the four quarters of DY2, HHSC also spent much time in DY2, particularly in Q3 and Q4, working with CMS on changes to the Category 3 options in the RHP Planning Protocol and the target setting methodology for Category 3. While this work was not completed in DY2, significant progress was made.

Also, HHSC worked with CMS and the RHP anchors to develop the Anchor Administrative Claiming Protocol during DY2. HHSC submitted the proposed protocol to CMS in DY3, but during DY2 did most of the development work, collected information from anchors on their anticipated anchor administrative activities and costs for DY2 – DY5, and compiled the information for the RHPs into the proposed protocol.

Major UC Program Activities During DY2

Oct 2012
- DY1 4th Quarter Advance Transition Waiver Payment is issued totaling $618,006,469.
- Final DY1 Uncompensated Care (UC) Tool Applications are due to HHSC on October 26, 2012.

Nov 2012
- HHSC processes 347 Texas Hospital UC Tool (TXHUC) and Texas Physician UC Tool (TXPUC) applications
- HHSC reviews and returns 149 incomplete UC Tool Applications for resubmission.
- HHSC creates two (2) custom UC tool applications for new providers in DY1.

- HHSC creates nine (9) custom UC tool applications for institutions of mental disease providers

Dec 2012 – Jan 2013
- HHSC reviews 149 resubmitted UC Tools; 32 are returned to providers a second time for additional revisions/updates with a requested 30-day turnaround.
- HHSC begins process of reviewing each UC Tool Application for logical quality assurance (QA) edits.
- HHSC develops initial UC DY1 payment database of UC costs for each provider.

Feb 2013 – Mar 2013
- HHSC adds DSH HSL, DSH payments and year to date UC payments to UC DY1 payment database.
- HHSC begins review of UC Tools for providers with UC Costs that passed logical edits.

Apr 2013
- HHSC creates Final DY1 UC Payment Calculation Spreadsheet and Aggregate Cap Limit Payment Methodology.
- HHSC finalizes UC DY1 Payment Database listing DY1 UC Tool Application Costs.
- HHSC loads DY1 Payment Database into Final DY1 UC Payment Calculation Spreadsheet.
- HHSC vets Final UC Costs with Hospital Industry.
- HHSC incorporates industry feedback into Final DY1 UC Payment Calculation Spreadsheet.

May 2013
- HHSC posts electronically an IGT Commitment Spreadsheet including: 1) maximum Final DY1 Payment; 2) maximum Final DY1 Intergovernmental Transfer (IGT); 3) space for providers to enter "Proposed IGT Commitment amount"; and 4) the auto-populated "Final DY1 Payment" based on the proposed IGT commitment amount.
- Government Entities submit "Proposed IGT Commitment Amounts" to HHSC.
- HHSC determines that based on total "proposed IGT Commitment Amounts", a "haircut reduction" is necessary to prevent the total payable amount for the demonstration year from exceeding the Total Aggregate Cap Limit. HHSC calculates the pro-rated haircut percentage reduction, applies it to the total payable amount, and re-posts the maximum Final DY1 Payment and maximum IGT Amount along with IGT transfer dates on the HHSC website.

Jun 2013
- Government Entities submit IGT transfers for the Final DY1 UC Payment

- HHSC issues the Final DY1 UC payment totaling $1,160,823,506 in June 2013.

Jul 2013
- HHSC submits accounts receivables and other adjustments for Final DY1 UC providers totaling ($70,772,091).

Aug 2013
- HHSC processes a 2013 DY2 Advance Waiver Payment totaling $1,493,628,112 in August 2013.

Upcoming UC Program Events in DY3

Jan 2014
- HHSC plans to issue a combined DSH/TXHUC DY2 application tool and the TXPUC application to providers

Feb 2014
- Completed DY2 DSH/TXHUC and TXPUC application tools expected from providers

Mar – May 2014
- HHSC processes applications.
- Calculation of HSLs occurs and verified by consultant and by provider applicants.

May/Jun 2014
- Final DY2 payments made to providers.

DY2 DSRIP Reporting in October 2013(FFY2014 Q1)
The second opportunity for providers to report metric achievement for DY2 was in October 2013. HHSC received October reporting from over 320 providers (if a provider participated in more than one RHP, they would be counted for each RHP) for over 1,250 Category 1 or 2 projects, 1,800 Category 3 outcomes, and over 150 Category 4 hospital reports. Most metrics (over 93 percent) were approved for the October reporting period for an estimated $1.088 billion in DSRIP payments out of a total of over $1.165 billion that was reported and over $1.688 billion that could have been reported. Actual payments will be dependent on available IGT and processed in FFY2014 Q2.

Learning Collaborative Plans Submitted in October 2013
As required by the Program Funding and Mechanics Protocol, all of the Regional Health Partnerships submitted learning collaborative plans to HHSC by October 1, 2013. These learning collaborative plans reflect opportunities for shared learning among the approved DSRIP

projects in the region, and in some cases across regions. Tier 4 RHPs were allowed to submit a request not to conduct their own regional learning collaboratives if they have a compelling justification, such as the lack of administrative capacity to do so.

Of the 20 RHPs, 16 plan to coordinate learning collaboratives within their regions for their approved DSRIP providers, including four Tier 4 regions. Two Tier 4 regions together plan to offer a joint opportunity for their providers to take part in peer-to-peer learning, as well the ability participate in the learning collaborative of a nearby larger region in addition to the statewide learning collaborative. The remaining two regions, both Tier 4, have requested not to conduct their own learning collaborative due to lack of administrative capacity, but plan to take part in the statewide learning collaborative and in the learning collaborative of a nearby larger region.

Summary of RHP Milestone Achievement in DY2
Each of the 20 RHPs submitted an annual report to HHSC by December 15, 2013, that outlines the activities and achievements of the RHP for DY2. Those reports will be made available to CMS for review. HHSC also is providing a high-level summary of performance achievement by each RHP based on the two DY2 reporting periods – August 2013 and October 2013. This data is included in Attachment W – DY2 DSRIP Reporting by RHP Summary. Please note that the eligible payment amounts are contingent on available intergovernmental transfer (IGT) funds, so actual payments likely will be a little lower than eligible payments.

Projected DY3 DSRIP Payments
While HHSC's Financial Services staff will provide the official estimates of potential DSRIP payments to CMS for each quarter, based on October 2013 reporting, in which just over 93 percent of DSRIP reporting was approved, if the same percent is achieved in DY3, then HHSC estimates that DSRIP providers will earn over 1 billion dollars in DY3 DSRIP funds for each of the DY3 reporting periods – April and October 2014. This assumes that 50 percent of achievement is reported in each of the two DY3 reporting periods. It does not include DY2 metrics carried forward into DY3, so the total payment amounts for July 2014 (based on April 2014 reporting) and January 2015 (based on October 2014 reporting) likely will be higher that what is reflected below.

RHP	DSRIP Allocation DY3	50% reported	93.17% approved
RHP 1	$ 103,858,509	$ 51,929,255	$ 48,382,487
RHP 2	$ 85,349,084	$ 42,674,542	$ 39,759,871
RHP 3	$ 500,106,068	$ 250,053,034	$ 232,974,412
RHP 4	$ 107,858,568	$ 53,929,284	$ 50,245,914
RHP 5	$ 68,404,824	$ 34,202,412	$ 31,866,387

RHP 6	$ 266,338,472	$ 133,169,236	$ 124,073,777
RHP 7	$ 150,926,158	$ 75,463,079	$ 70,308,951
RHP 8	$ 26,202,742	$ 13,101,371	$ 12,206,547
RHP 9	$ 312,731,216	$ 156,365,608	$ 145,685,837
RHP 10	$ 222,162,047	$ 111,081,023	$ 103,494,189
RHP 11	$ 29,875,449	$ 14,937,725	$ 13,917,478
RHP 12	$ 90,597,799	$ 45,298,900	$ 42,204,985
RHP 13	$ 17,879,588	$ 8,939,794	$ 8,329,206
RHP 14	$ 57,506,763	$ 28,753,382	$ 26,789,526
RHP 15	$ 115,223,924	$ 57,611,962	$ 53,677,065
RHP 16	$ 33,832,919	$ 16,916,460	$ 15,761,066
RHP 17	$ 16,598,742	$ 8,299,371	$ 7,732,524
RHP 18	$ 29,673,940	$ 14,836,970	$ 13,823,605
RHP 19	$ 25,016,302	$ 12,508,151	$ 11,653,844
RHP 20	$ 12,444,630	$ 6,222,315	$ 5,797,331
Total	$ 2,272,587,747	$ 1,136,293,873	$ 1,058,685,002

B. Policy and Administrative Difficulties

The Texas DSRIP program has evolved during DY2, encountering many policy and administrative challenges as HHSC, CMS, RHP anchors, and DSRIP providers worked to develop and implement a DSRIP program that is very different than any other state's DSRIP program.

The volume and variety of providers (about 300) and projects (over 1200 approved so far and over 250 still to be reviewed) in Texas has led to the DSRIP program becoming extremely complex. The overarching challenge facing HHSC has been how to manage such a large, new program given aggressive timelines and limited resources. The HHSC waiver team added staff in DY1 and DY2 to support DSRIP activities, with 16 full-time positions now dedicated to DSRIP and a number of other staff within the agency playing key support roles for DSRIP, HHSC also relies heavily on a number of contractors to support DSRIP, including Deloitte Consulting, the Texas Medical Foundation, Health Management Associates, and Cooper Consulting.

Timeline pressure up front resulted in more work later in the process. For example, CMS approved the initial Program Funding and Mechanics (PFM) Protocol and RHP Planning Protocol in August-September 2012, at the end of DY1. There was pressure to get the protocols in place so that RHP plans with DSRIP projects could be developed, submitted, reviewed by

HHSC and CMS, and implemented. However, since the protocols initially were approved, there have been multiple amendments to the protocols to further refine and strengthen the program. These changes midstream have been challenging for providers as they work not only to implement their projects, but also to understand and comply with requirements added or changed after they developed their projects.

Two of the policy areas that have been the greatest challenge have been Category 3 and valuation review.

Category 3

As HHSC understood the waiver Special Terms and Conditions, Category 3 was specific to inpatient hospital quality initiatives for which outcomes during the term of the waiver could be measured. As HHSC negotiated the DSRIP protocols with CMS, CMS required that Category 3 instead be quality outcomes tied to all DSRIP Category 1 and 2 projects, most of which are not inpatient quality initiatives and many of which are not performed by hospitals. It has been a challenge for HHSC and CMS to arrive at Category 3 outcome measures appropriate for all Texas DSRIP projects and providers, and also to establish a target setting methodology that is feasible to implement in the remaining term of the waiver. Significant progress was made during DY2, and HHSC and CMS are working to finalize the Category 3 measures and framework in FFY14 Q2.

Valuation

The volume and variety of Texas' DSRIP providers made setting an up-front DSRIP valuation methodology more challenging than in some other states where DSRIP is limited to a number of large public hospital systems. Texas DSRIP providers had the ability to set their project valuation within certain parameters established in the PFM Protocol and were required to include a narrative justification supporting their proposed valuation. CMS and HHSC have spent a lot of time since the projects were submitted to identify projects that may be overvalued relative to other projects and to settle project valuation. Since DSRIP payments are incentive payments and not cost based, and since each project is different, it has been a challenge to review project valuation. Project valuation review for DY2-3 for projects submitted by April 2013 was finalized by CMS in November 2013 (FFY14 Q1). The review of DY4-5 valuation continues for the initially submitted projects and hopefully will be completed in FFY14 Q2.

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.

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

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

Attachment E – SDS STAR GeoMapping. The attachment shows the State's GeoMapping analysis for STAR plans for 2013 SFQ3.

Attachment G -- SDS STAR+PLUS GeoMapping. The attachment provides results of the State's GeoMapping analysis for STAR+PLUS plans for 2013 SFQ2.

Attachment H – SDS Dental GeoMapping. The attachment includes the State's GeoMapping analysis for STAR and STAR+PLUS dental access for 2013 SFQ2.

Attachment I –MCO STAR GeoMapping Summary. The attachment includes the STAR plans' self-reported GeoMapping results for 2013 SFQ2.

Attachment J – MCO STAR+PLUS GeoMapping Summary. The attachment includes the STAR+PLUS plans' self-reported GeoMapping results for 2012 SFQ2.

Attachment K – MCO Children's Medicaid Dental Services GeoMapping Summary. The attachment includes the dental plans' self-reported GeoMapping results for 2013 SFQ2.

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

Attachment M – 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 N – Complaints and Appeals to Managed Care Organizations. The attachment includes STAR and STAR+PLUS complaints and appeals received by plans in 2013 SFQ3.

Attachment O – Complaints to HHSC. The attachment includes information concerning complaints received by the State in 2013 SFQ3.

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

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

Attachment R– Provider Fraud and Abuse. The attachment represents a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period, 2013 SFQ3-4.

Attachment S– Pharmacy Geomapping. The attachment includes the SDS pharmacy GeoMapping results for 2013 SFQ2 .

Attachment T-EQRO Quality Reports. The attachment includes draft reports from the EQRO on Children with Special Health Care Needs, MCO Report Cards, the 2012 STAR Adult Survey Report, and the 2013 Quality of Care Report.

Attachment U - Dental Stakeholder Presentation. The attachment includes the HHSC presentation at the quarterly dental stakeholders meeting.

Attachment V – STAR and STAR+PLUS Claims Summary. The attachment is a summary of the managed care organizations' 2013 SFQ1 and SFQ2 claims adjudication results

Attachment W – DY2 DSRIP Reporting by RHP Summary. The attachment is a summary of the demonstration year 2 DSRIP reporting by RHP.

Attachment X – Evaluation Meetings with External Stakeholders. The attachment includes HHSC evaluation meetings with external waiver stakeholders for DY2.

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