Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Quarterly Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2016 State Fiscal Quarter 4, June - August

Demonstration Year (DY) 5, October 1, 2015 - September 30, 2016

TABLE OF CONTENTS

I. Introduction 3

A. Managed Care Plans Participating in the Waiver Program 3

B. Monitoring Managed Care Plans 4

C. Demonstration Funding Pools 5

II. Enrollment and Benefits Information 5

A. Eligibility and Enrollment 5

B. Enrollment Counts for the Quarter By Population 15

C. Disenrollment 15

D. Enrollment of Members with Special Health Care Needs 16

E. Medicaid Eligibility Changes 19

F. Anticipated Changes in Populations or Benefits 19

III. Delivery Networks and Access 20

A. Provider Networks 20

B. Provider Open Panel 22

C. Service Utilization 25

D. GeoAccess 32

E. Provider 24/7 Availability 35

Out-of-Network Utilization 37

IV. Outreach/Innovative Activities to Assure Access 40

A. Enrollment Broker and Plan Activities 40

B. Dental Stakeholder Meeting 41

C. Medicaid Managed Care Advisory Committee 41

D. Public Forum 41

E. Independent Consumer Supports System Plan 42

F. HHSC Managed Care Initiatives 43

V. Collection and Verification of Encounter Data and Enrollment Data. 44

VI. Operational/Policy/SystemsFiscal Developments/Issues 44
A. Update from Prior Quarter 44
B. Litigation Update 45
C. New Issues 48
D. Claims Summary 49
VII. Action Plans for Addressing Any Issues Identified 52
VIII. Financial/Budget Neutrality Development/Issues 52
IX. Member Month Reporting 53
X. Consumer Issues 53
A. Hotline Call Volume and Performance 54
B. Complaints and Appeals Received by Plans 57
C. Complaints Received by the State 64
XI. Quality Assurance/Monitoring Activity 67
A. DY5 Quarter 4 Update 67
B. Annual Update 68
XII. Demonstration Evaluation 71
A. Overview of Evaluation 71
B. Summary of Evaluation Activities 71
C. Activities Planned in Next Quarter 75
XIII. Regional Healthcare Partnership Participants 76
A. Accomplishments 76
B. Policy, Administrative and Financial Difficulties 86
Enclosures/Attachments 87
State Contacts 89
Acronym list 90

I. INTRODUCTION

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

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

This report documents the State's progress in meeting these goals. It addresses the quarterly, biannual, 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 14, 21, 23, 25(e), 40(a), (b), and (c), 41(b) and (c), 42(a), 51, 55, 68, 70, and 71. These STCs require the State to report on various topics, including: enrollments and disenrollments; access to care; anticipated changes in populations or benefits; network adequacy; encounter data; operational, policy, systems, and fiscal issues; action plans for addressing identified issues; budget neutrality; member months; consumer issues; quality assurance and monitoring; demonstration evaluation; and Regional Healthcare Partnerships (RHPs). STC 70 also 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 require 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 Quarter (SFQ) cycle; therefore, some of the quarterly information presented in this report is based on data compiled for 2016 SFQ4 (June - August) instead of Demonstration Year (DY) 5, Q4 ("2016 D4," covering July 1, 2016 -September 30, 2016). Throughout the report, the State has identified whether the quarterly data relates to 2016 SFQ4 or 2016 D5.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2016 SFQ4, 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 delivery areas (SDAs) and 13 STAR+PLUS SDAs while each dental plan provides statewide services. Please refer to Attachment A for a list of the STAR, STAR+PLUS, and Dental plans by area.

B. MONITORING MANAGED CARE PLANS

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

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

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

HHSC is committed to ensuring compliance with the federal HCBS regulations. In accordance with STC 42(a), HHSC has taken the following steps towards compliance:

1. In November 2016, HHSC submitted an amended Texas Statewide Settings Transition Plan detailing compliance, remediation strategies, and timelines for the STAR+PLUS waiver program operating under the State's 1115 Demonstration waiver to CMS.
2. Throughout 2016, HHSC provided multiple stakeholder meeting opportunities to highlight the upcoming availability of the HCBS provider surveys, answer stakeholder questions, and provide updated information about the Texas transition plan.
3. HHSC surveyed a representative sample of individuals served through HCBS STAR+PLUS who received assisted living or adult foster care services as part of its validation of the provider surveys also completed in 2016. These surveys were complete by the end of 2016. HHSC is currently in the process of analyzing the external surveys from provider, participant, and service coordinator surveys.

C. DEMONSTRATION FUNDING POOLS

The Section 1115 Demonstration establishes two funding pools created by savings generated from managed care expansion and diverted supplemental payments to reimburse providers for uncompensated care costs and 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 Regional Healthcare Partnerships (RHPs) that are anchored by public hospitals or other specific government entities. RHPs identified performance areas for improvement that may align with the following four broad categories to be eligible for incentive payments: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements, and (4) population focused improvements. The non-Federal share of funding for pool expenditures is largely financed by State and local intergovernmental transfers (IGTs).

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

II. ENROLLMENT AND BENEFITS INFORMATION

This section addresses STCs 25(e), 40(a) and (b), 70 including quarterly trends and issues related to STAR, STAR+PLUS, and Dental Program eligibility and enrollment; enrollment counts for the quarter; Medicaid eligibility changes; anticipated changes in populations and benefits; and disenrollment from managed care. Unless otherwise provided, quarterly managed care data covers the 2016 SFQ1 through SFQ4 reporting period (September 2015 - August 2016) instead of 2016 DY5 (October 1, 2015 - September 30, 2016). Supporting data are located in Attachment B.

A.ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 25(e) and 70. Attachment B includes enrollment summaries for the three managed care programs. The enrollment data in this subsection are based on prospective managed care enrollment counts in the last month of the quarter and represent a snapshot of the number of members enrolled in Texas Medicaid managed care programs and health plans.

The total enrollment in Texas Medicaid managed care programs, STAR, STAR+PLUS and Dental, decreased by -0.69% from 2016 SFQ3 to 2016 SFQ4. Overall enrollment for the 2016 fiscal year decreased by -0.61%.

1. STAR

The number of members enrolled in STAR plans increased by 0.82% from 2,837,660 in 2016 SFQ3 to 2,860,955 in 2016 SFQ4. Across the STAR program, six MCOs reported a decrease in membership of less than 4% from SFQ3 to SFQ4 shown in the following tables. During 2016 SFQ4, six MCOs and four SDAs reported decreases in member enrollment but these declines were very small (MCOs: Christus (-1.14%), Blue Cross Blue Shield (-0.97%), Community First (-0.84%), Parkland (-0.83%), Molina (-0.32%) and Aetna (-0.07%); SDAs: (MRSA Central SDA (-3.09%), Jefferson (-0.40%), Travis (-0.20%) and Dallas (-0.12%). In contrast, the largest increases in member enrollment was reported for Sendero MCO (3.08%) and El Paso SDA (3.57%).

Enrollment by STAR MCO (2016 SFQ3- 2016 SFQ4)

STAR	2016 Q3	2016 Q4	Total Change	Percent Change from 2016 SFQ3 to 2016 SFQ4
Statewide	2,837,660	2,860,955	23,295	**0.82%**
Aetna	69,760	69,712	(48)	**-0.07%**
Amerigroup	550,635	553,043	2,408	**0.44%**
BCBS	24,026	23,793	(233)	**-0.97%**
CHC	231,436	234,427	2,991	**1.29%**
Christus	5,719	5,654	(65)	**-1.14%**
Community 1st	105,866	104,974	(892)	**-0.84%**
Cook Children's	96,733	97,601	868	**0.90%**
Driscoll	138,593	141,538	2,945	**2.12%**
El Paso 1st	65,970	67,986	2,016	**3.06%**
FirstCare	92,875	93,453	578	**0.62%**
Molina	97,506	97,192	(314)	**-0.32%**
Parkland	165,980	164,597	(1,383)	**-0.83%**
Scott & White	42,374	42,963	589	**1.39%**
Sendero	12,350	12,730	380	**3.08%**
Seton	17,526	17,845	319	**1.82%**
Superior	679,721	682,779	3,058	**0.45%**
Texas Children's	323,520	331,702	8,182	**2.53%**
United	117,070	118,966	1,896	**1.62%**

STAR Enrollment by SDA (2016 SFQ3 – 2016 SFQ4)

STAR	2016 Q3	2016 Q4	Total Change	Percent Change from 2016 SFQ3 to 2016 SFQ4
Statewide	2,837,660	2,860,955	23,295	**0.82%**
Bexar	241,504	242,534	1,030	**0.43%**
Dallas	385,497	385,020	-477	**-0.12%**
El Paso	119,685	123,959	4,274	**3.57%**
Harris	668,559	681,963	13,404	**2.00%**
Hidalgo	348,936	350,084	1,148	**0.33%**
Jefferson	73,153	72,857	-296	**-0.40%**
Lubbock	73,814	74,783	969	**1.31%**
MRSA Central	132,088	128,003	-4,085	**-3.09%**
MRSA Northeast	162,003	163,735	1,732	**1.07%**
MRSA West	150,413	153,966	3,553	**2.36%**
Nueces	82,862	83,887	1,025	**1.24%**
Tarrant	257,883	259,184	1,301	**0.50%**
Travis	141,263	140,980	-283	**-0.20%**

Market Share by STAR MCO (2015-2016)

The STAR market share distribution by MCOs fluctuated slightly from the prior quarter, with a maximum percentage point change from 2016 SFQ3 to 2016 SFQ4 of 0.24 percentage points for Texas Children's as shown in the table below.

STAR	2016 Q1	2016Q2	2016Q3	2016Q4	Percentage Point Change from 2016 Q3 to 2016 Q4
Aetna	2.50%	2.46%	2.46%	2.45%	-0.01%
Amerigroup	19.68%	19.39%	19.40%	19.42%	0.01%
BCBS	0.81%	0.84%	0.85%	0.84%	-0.01%
CHC	8.08%	8.13%	8.16%	8.23%	0.07%
Christus	0.22%	0.21%	0.20%	0.20%	0.00%
Community 1st	3.76%	3.76%	3.73%	3.69%	-0.05%
Cook Children's	3.40%	3.43%	3.41%	3.43%	0.02%
Driscoll	4.70%	4.82%	4.88%	4.97%	0.08%
El Paso 1st	2.26%	2.30%	2.32%	2.39%	0.06%
FirstCare	3.20%	3.22%	3.27%	3.28%	0.01%
Molina	3.45%	3.14%	3.44%	3.41%	-0.02%
Parkland	6.13%	6.07%	5.85%	5.78%	-0.07%
Scott & White	1.37%	1.48%	1.49%	1.51%	0.02%
Sendero	0.42%	0.42%	0.44%	0.45%	0.01%
Seton	0.58%	0.60%	0.62%	0.63%	0.01%
Superior	23.88%	24.05%	23.95%	23.97%	0.02%
Texas Children's	11.43%	11.57%	11.40%	11.64%	0.24%
United	4.12%	4.11%	4.13%	4.18%	0.05%

2. STAR+PLUS

The number of members enrolled in STAR+PLUS plans increased by 0.89% from 537,512 in 2016 SFQ3 to 542,297 in 2016 SFQ4. Most STAR+PLUS plans had only slight fluctuations with Amerigroup having the largest enrollment increase (1.18%). Among SDAs, Tarrant (1.90%) had the largest increase in member enrollment. The following tables show the change in enrollment in STAR+PLUS by MCO and SDA from 2016 SFQ3 to 2016 SFQ4.

Enrollment by STAR+PLUS MCO (2016 SFQ3 – 2016 SFQ4)

STAR+PLUS	Sum of 16Q3 Enroll	Sum of 16Q4 Enroll	Total Change	Percentage Change
Statewide	537,512	542,297	4785	0.89%
Amerigroup	137,866	139,486	1620	1.18%
Cigna-HealthSpring	50,656	50,823	167	0.33%
Molina	89,708	90,466	758	0.84%
Superior	144,057	145,390	1333	0.93%
United	115,225	116,132	907	0.79%

Enrollment by STAR+PLUS SDA (2016 SFQ3 – 2016 SFQ4)

STAR+PLUS	2016 Q3	2016 Q4	Total Change	Percentage Change
Statewide	537,512	542,297	4,785	**0.89%**
Bexar	47,224	47,821	597	**1.26%**
Dallas	61,779	62,752	973	**1.57%**
El Paso	20,697	21,062	365	**1.76%**
Harris	104,347	105,835	1,488	**1.43%**
Hidalgo	67,777	68,276	499	**0.74%**
Jefferson	20,335	20,295	-40	**-0.20%**
Lubbock	13,732	13,678	-54	**-0.39%**
MRSA Central	29,593	29,840	247	**0.83%**
MRSA Northeast	46,250	46,260	10	**0.02%**
MRSA West	38,149	38,162	13	**0.03%**
Nueces	21,972	21,928	-44	**-0.20%**
Tarrant	39,759	40,516	757	**1.90%**
Travis	25,898	25,872	-26	**-0.10%**

The STAR+PLUS market share remained relatively stable with only slight changes from SFQ3 to SFQ4. Amerigroup's market share increased from the prior quarter (0.35 percentage points),

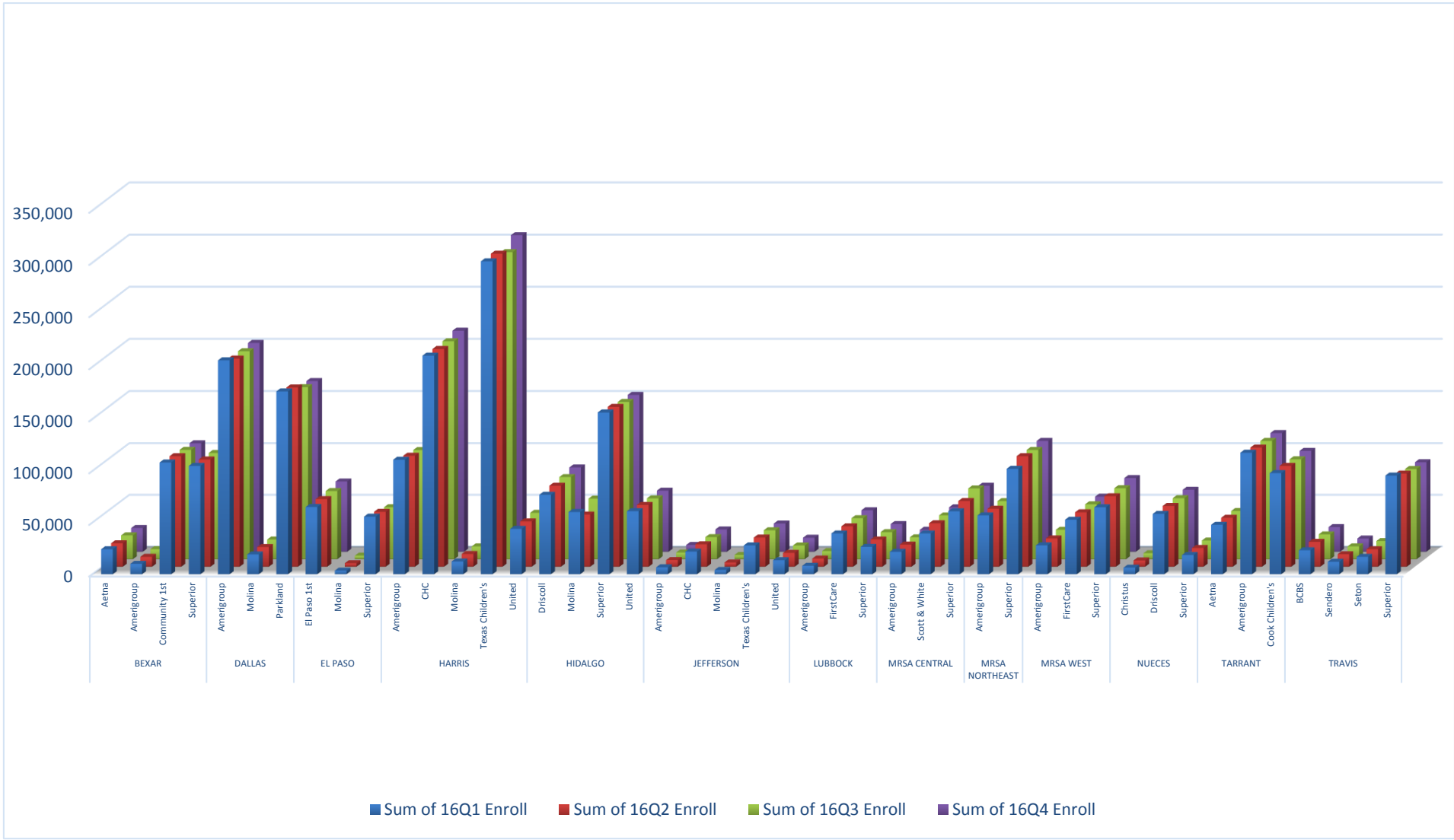
the MCO reported the largest STAR+PLUS market share. Cigna-Health Spring, Molina, and United Health Care market had slightly larger market shares in 2016 SFQ4 than SFQ3. Superior also reported an increase in market share from the previous quarter. Despite these changes, the order of MCOs by market share remained consistent as shown in the table below.

Market Share by STAR+PLUS MCO (2015-2016)

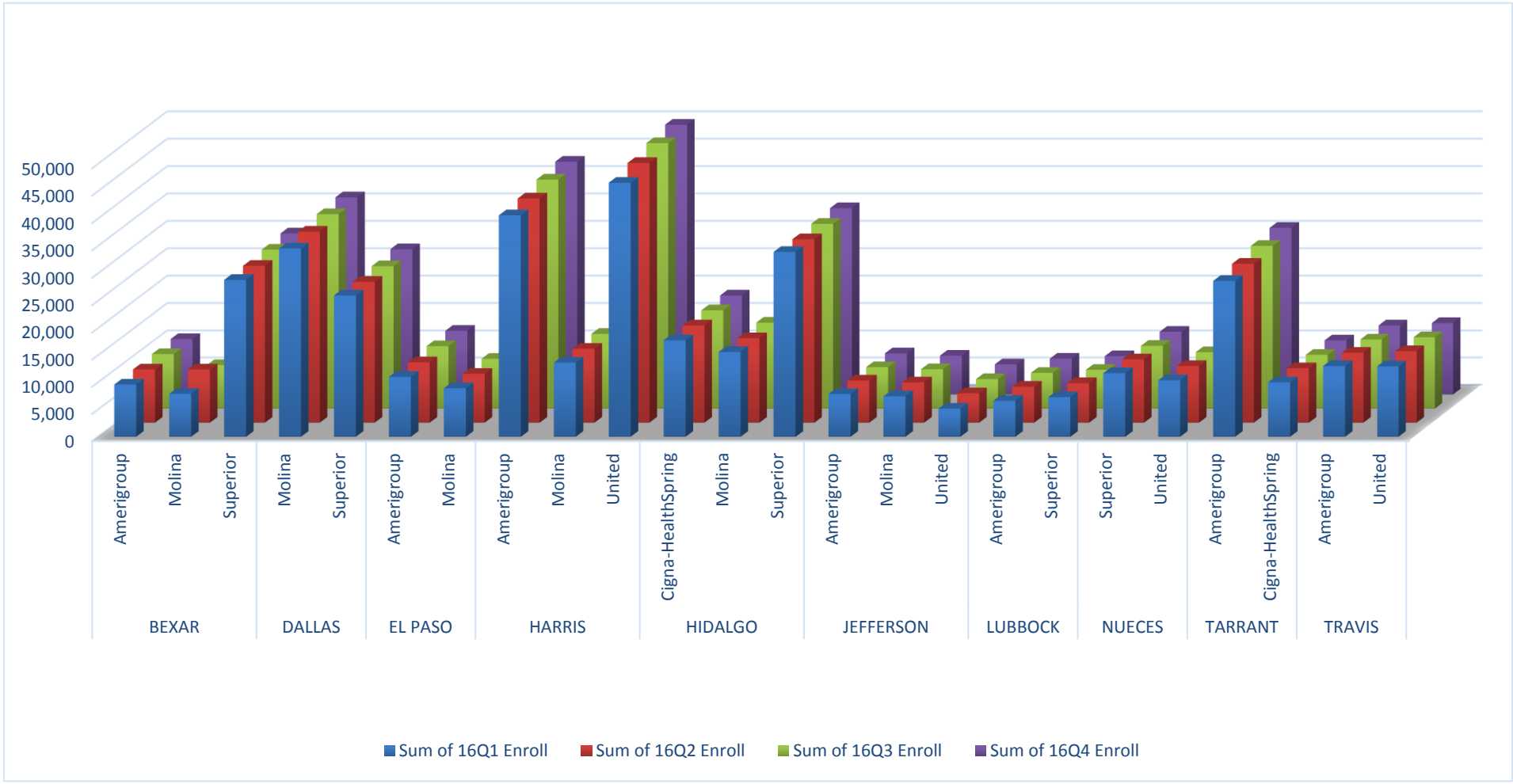
STAR+PLUS	2016 Q1	2016 Q2	2016 Q3	2016 Q4	Percentage Point Change from 2016 Q3 to 2016 Q4
Amerigroup	25.48%	25.42%	25.65%	26.00%	0.35%
Cigna-HealthSpring	9.52%	9.49%	9.42%	9.47%	0.05%
Molina	16.60%	16.88%	16.69%	16.86%	0.17%
Superior	27.12%	26.83%	26.80%	27.10%	0.30%
United	21.28%	21.39%	21.44%	21.65%	0.21%

The two following graphs show STAR and STAR+PLUS quarterly enrollment by MCO and SDA from SF16Q1 to SF16Q4. The third graph shows STAR+PLUS quarterly enrollment in the MRSA SDAs by MCO since the program has been expanded to the MRSA SDAs.

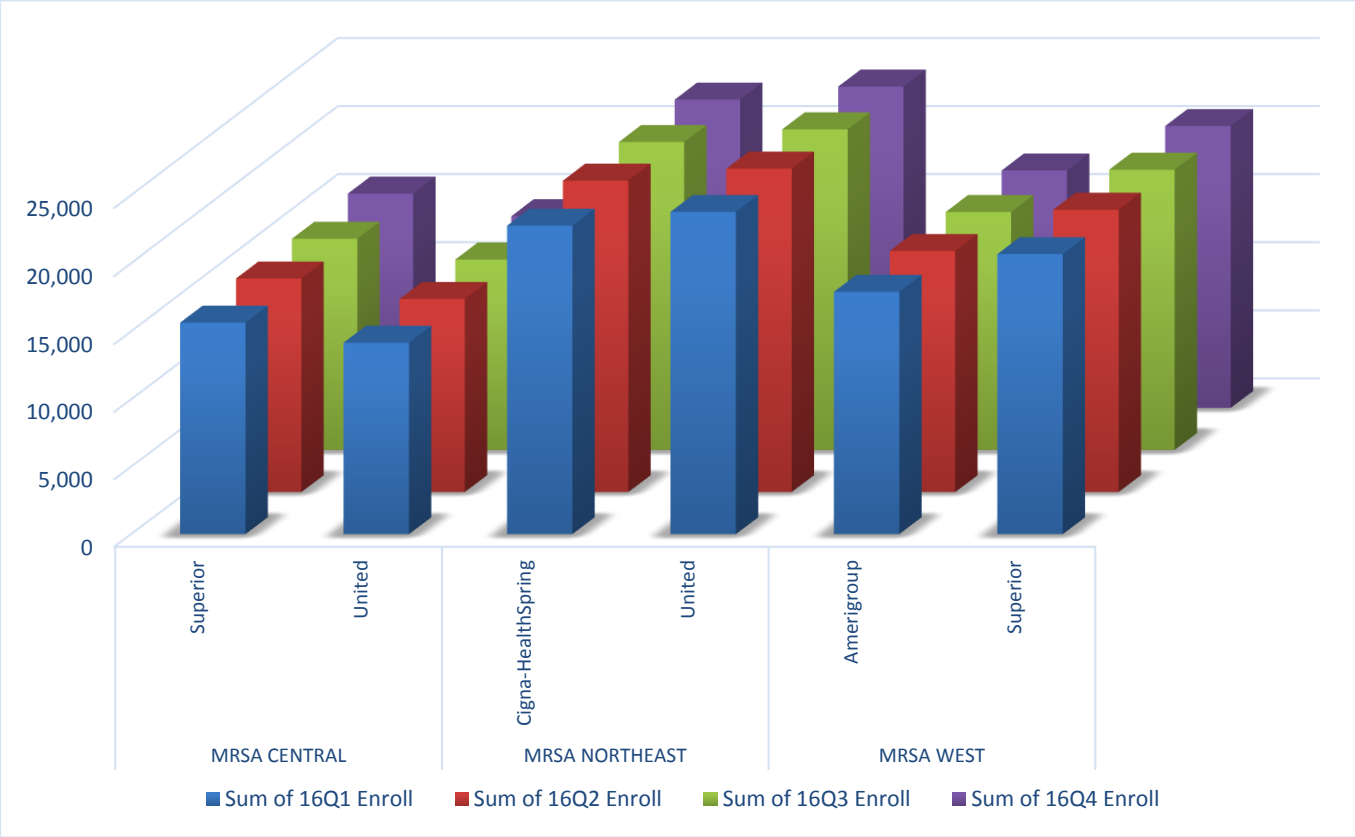
STAR Program Enrollment by MCO and Service Delivery Area (2016 SFQ1-2016 SFQ4)



STAR+PLUS Non-MRSA Program Enrollment by MCO and Service Delivery Area (2016 SFQ1-2016 SFQ4)



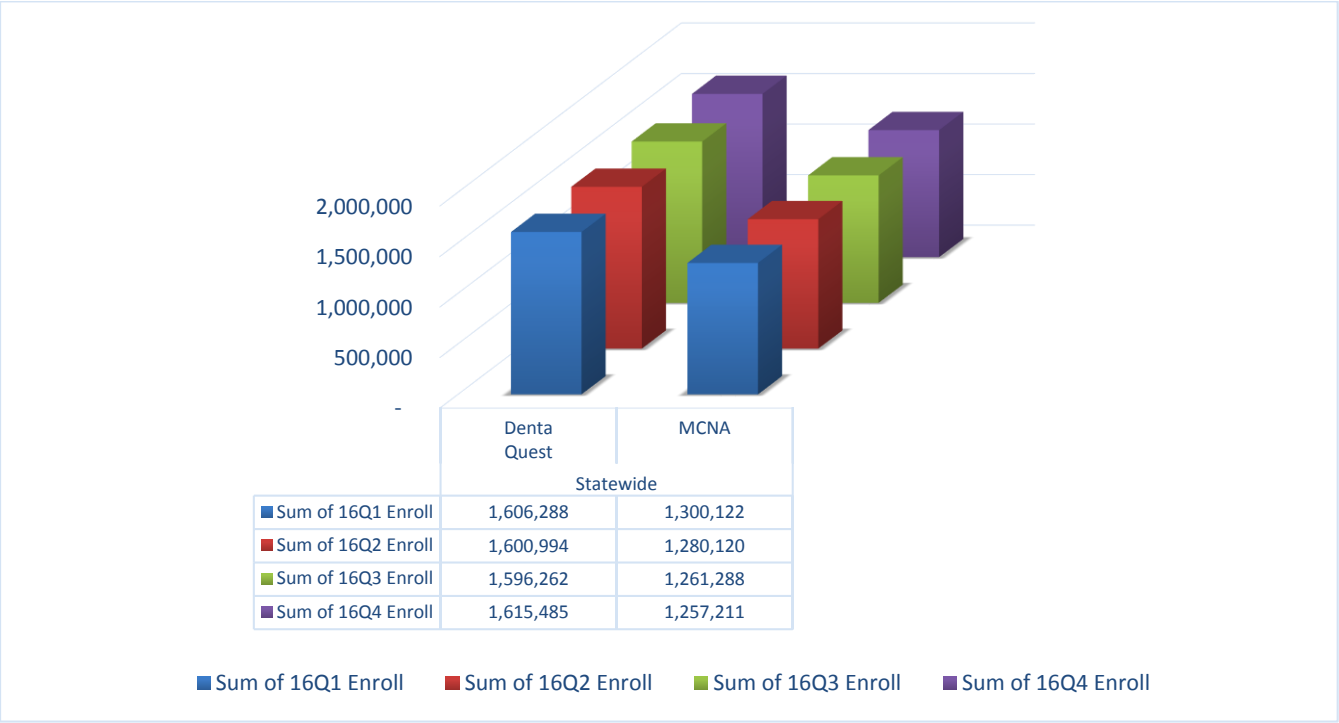
STAR+PLUS MRSA Program Enrollment by MCO and Service Delivery Area (SFY2016 Q1 through 2016 SFQ4)



3. Dental Program

Total enrollment in the Dental Program increased by 0.53% to 2,872,696 members during 2016 SFQ4.

Dental Program Enrollment Statewide (2016 SFQ1 -2016SFQ4)



Dental Market Share Statewide (2016 SFQ1 - SFQ4)

Market share in the Dental Program remained steady (within a percentage point): DentaQuest had approximately 56% while MCNA maintained at 44%.

Dental	2016 Q1	2016 Q2	2016 Q3	2016 Q4	Percent Point Change from 2016 Q3 to 2016 Q4
DentaQuest	55.27%	55.57%	55.86%	56.07%	0.21%
MCNA	44.73%	44.43%	44.14%	43.64%	-0.50%

B. ENROLLMENT COUNTS FOR THE QUARTER BY POPULATION

This subsection includes quarterly enrollment counts as required by STC 70. Due to the time required for the data collection process, unique member counts per quarter are reported on a two-quarter lag. The following table includes enrollment counts for the 2016 D5. Enrollment counts are based on persons and not member months.

Enrollment Counts (DY5 Q2 January 2016-March 2016)Demonstration Populations	Total Number Served
Adults	332,584
Children	2,824,696
AMR (non MRSA - pre Sep14)	384,380
Disabled	439,845

C. DISENROLLMENT

This subsection of the report addresses STC 40(b). In 2016 SFQ3 and SFQ4, the enrollment broker, MAXIMUS, reported 1,603 plan changes processed. Comparing the number of STAR and STAR+PLUS disenrollment requests from Medicaid managed care to the fee-for-service (FFS) delivery model in 2016 SFQ3 and SFQ4 to the prior two quarters, the State received 20 disenrollment requests for the STAR program while the disenrollment requests remained the same at 19 for the STAR+PLUS program. No disenrollment requests were received for the Dental Program. Members or their representatives initiated all disenrollment requests in SFQ3 and SFQ4.

	STAR	STAR+PLUS	Dental
16Q1	12	13	1
16Q2	13	22	0
16Q3	13	19	0
16Q4	20	19	0

D. ENROLLMENT OF MEMBERS WITH SPECIAL HEALTH CARE NEEDS

This subsection of the report addresses STC 40(b) regarding the enrollment into managed care for people with special healthcare needs. The State's Medicaid application asks potential enrollees to identify any family members that have special health care needs (MSHCN). MSHCN means a member including a child or children with special health care needs (CSHCN) who (1) has a serious ongoing illness, a chronic or complex condition, or a disability that has lasted or is anticipated to last for a significant period of time, and (2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel. The State's enrollment broker conveys this and other information concerning potential MSHCN to health and dental plans, who then verify whether the members meet the plans' assessment criteria for MSHCN. All STAR+PLUS members and certain members enrolled in STAR such as Former Foster Care Children (FFCC) 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.

Contract language requires MCOs to include additional populations with the groups that must be identified as MSHCN including pregnant women identified as high risk and Early Childhood Intervention (ECI) program participants. There are also contractual requirements regarding

service management and developing appropriate service plans as needed for MSHCN requiring care coordination to meet short and long-term goals.

1. Reporting

The data presented in Attachment Q of this report shows a snapshot of the total number of MSHCN for 2016 State Fiscal Quarter 4 (2016 SFQ4). HHSC has established contractual requirements and a template for the MCOs to submit MSHCN data on a quarterly basis.

2. Analysis

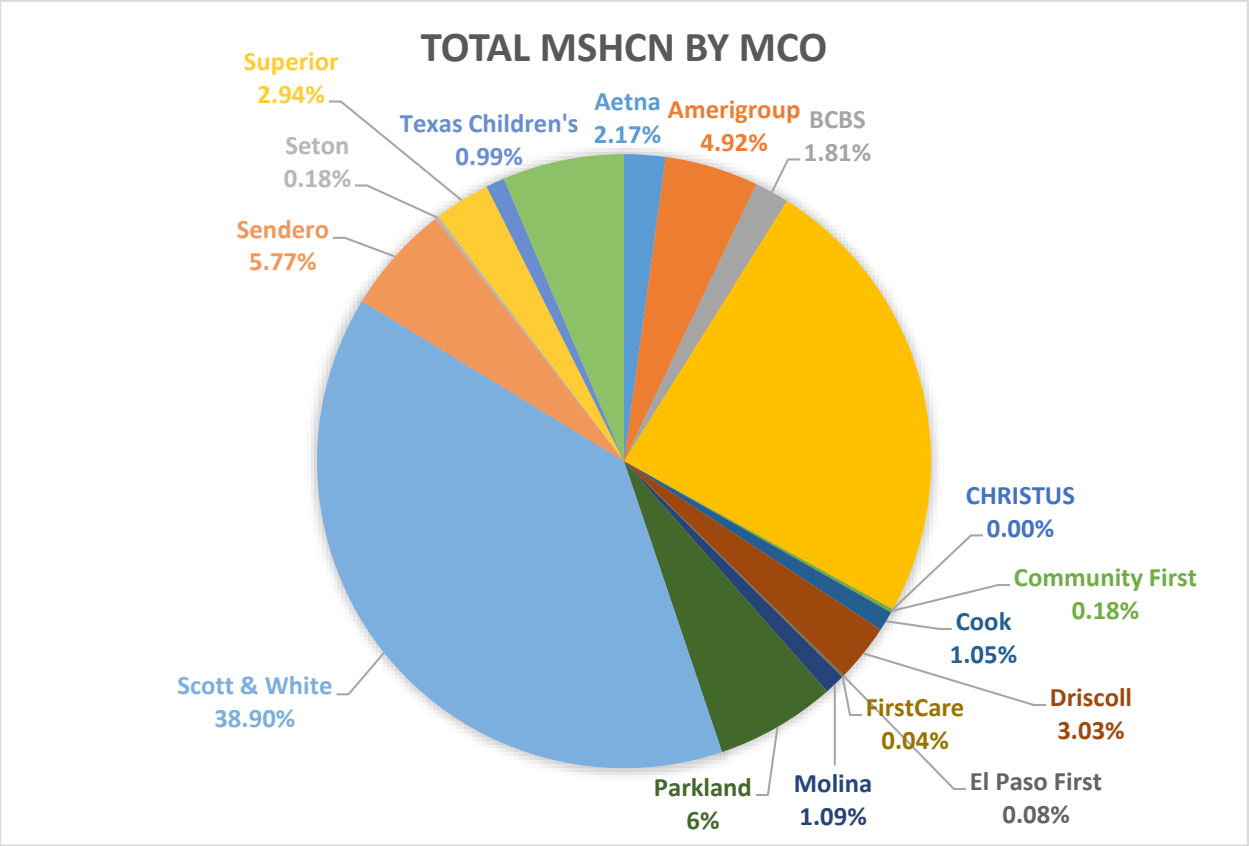
All STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR+PLUS plans are required to provide service coordination to all members. In 2016 SFQ4, STAR MCOs reported a total of 38,141 children and adults identified as MSHCN, which is 1.33% of all STAR members. See Attachment Q for detail by SDA and MCO.

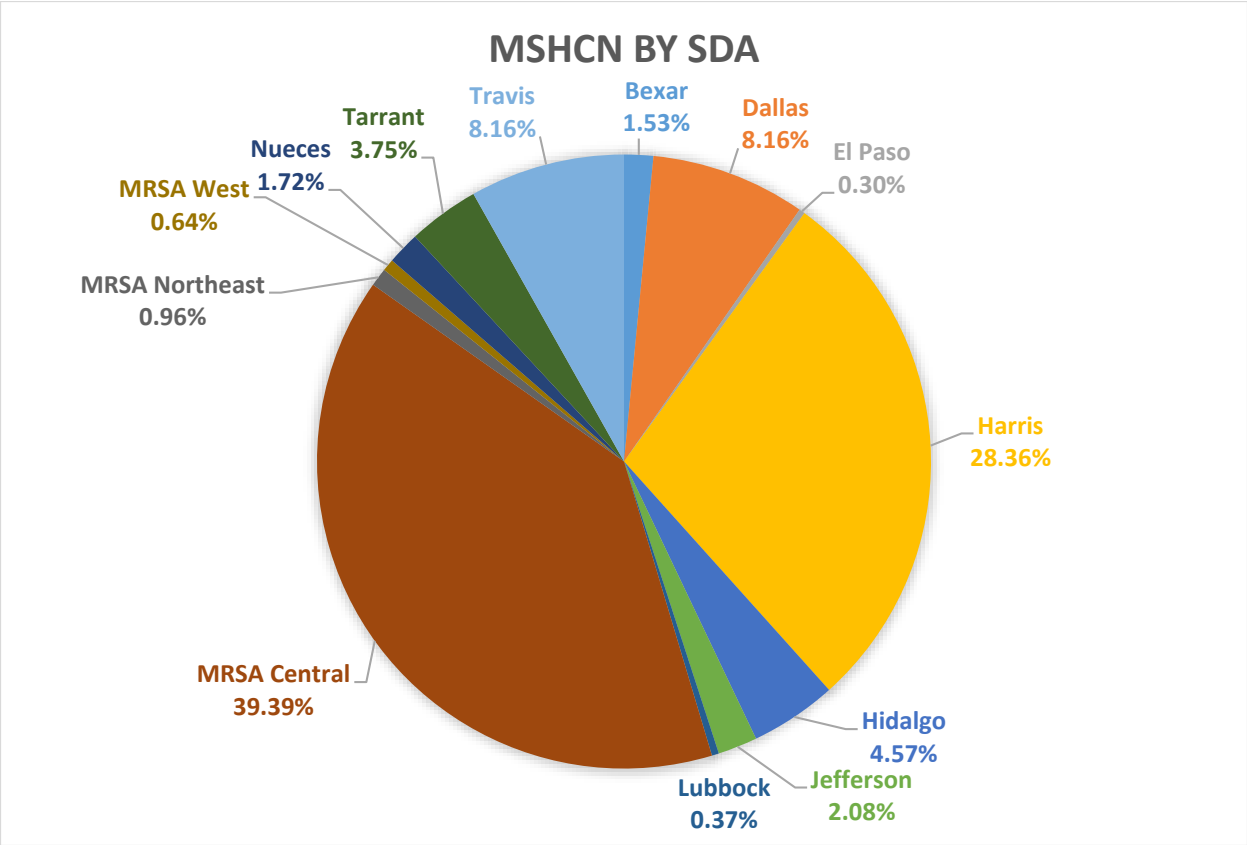
MCOs reported 27.51% of MSHCN with service plans in 2016 SFQ4. The overall percentage of STAR MSHCN with service plans has decreased since the last reporting period, but several MCOs have significantly increased the percentage of MSHCN with service plans. Aetna, Christus, Parkland, and United all reported 100% of MSHCN with service plans. Additionally, three other plans reported more than 90% of MSHCN with service plans (Cook with 99.25%, Driscoll with 94.83%, and Superior with 92.15%).

Approximately 28 percent (10,817) of all STAR MSHCN are concentrated in the Harris SDA. In 2016 SFQ4, Scott & White reported the largest number (14,837) of MSCHN. Moreover Scott & White reported the highest percent of enrollment (38.90 %) identified as MSHCN. Please refer to the pie charts below that provide illustrations of the breakdown of the statewide total MSHCN members by MCO and SDA. The statewide total numbers of MSHCN are inclusive of all of the SDAs which the MCO services. Attachment Q identifies the percentage total enrollment identified as MSHCN. Five STAR plans reported more than 2 percent of members classified as MSHCN: BCBS (2.91%), CHC (3.92%), Scott & White (34.53%), Sendero (17.28%), and United (2.05%). The majority of the remaining plans reported less than 1 percent of members as MSHCN.

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

The number of MSHCN has varied over time for some plans that have changed identification processes, and the total number of MSHCN increased since the last reporting period. For example some plans reported implementing member survey processes to verify MSHCN status.





E. MEDICAID ELIGIBILITY CHANGES

No eligibility changes were made to the 1115 waiver populations in 2016 D5.

F. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

STAR Kids

On November 1, 2016, children and young adults under the age of 21 who are not in state conservatorship and who receive Supplemental Security Income (SSI) or SSI-related Medicaid, who reside in a community-based intermediate care facility for individuals with an intellectual disability or a related condition (ICF-IID) or a nursing facility (NF), or who are served through one of the Medicaid 1915(c) waivers were transitioned from traditional Medicaid FFS, STAR, or STAR+PLUS Medicaid managed care to STAR Kids Medicaid managed care for the provision of their 1905(a) state plan services. Children and young adults enrolled in STAR Kids receive a continuum of services, including acute care, behavioral health, and state plan long-term services and supports (LTSS).

Children and young adults who currently receive services through the Medically Dependent Children Program (MDCP) will begin receiving their MDCP 1915(c) services from either a

STAR Kids or STAR Health MCO. Other 1915(c) Home and Community-Based Services (HCBS) waivers, NF services, and ICF-IID services will continue to be operated as they have historically been operated and will not be capitated services in the STAR Kids model. STAR Kids MCOs will provide service coordination for all members, including coordination with non-capitated HCBS that exist outside of this section 1115 demonstration. Children in the conservatorship of the Department of Family and Protective Services (DFPS) who have SSI or SSI-related Medicaid, or who are served through one of the 1915(c) waivers, are currently served through the STAR Health 1915(a) program and will continue in STAR Health after implementation of STAR Kids.

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

Currently, Medicaid for Breast and Cervical Cancer (MBCC) and Medicaid services for individuals in Adoption Assistance and Permanency Care Assistance (AAPCA) programs are delivered through traditional, fee-for-service (FFS) Medicaid. These services will transition from Medicaid FFS to Medicaid managed care. Starting September 1, 2017, MBCC benefits will be delivered through STAR+PLUS Medicaid managed care, and Medicaid benefits for individuals in AAPCA will be delivered through STAR and STAR Kids Medicaid managed care. Clients in AAPCA who have supplemental security income (SSI) or are enrolled in Medicare will be enrolled in STAR Kids. All other clients with AAPCA will be enrolled in STAR with the exception of a few populations.

Under managed care, about 5,000 MBCC clients will have access to unlimited prescriptions and service coordination and access to Long Term Service and Supports as needed through STAR+PLUS (services not available in Medicaid FFS). Additionally, 51,000 AAPCA clients will have access to enhanced service management through STAR and service coordination for those AAPCA children transitioning into STAR Kids (a service not available in Medicaid FFS).

III. DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly reporting requirements found in STCs 25(e), 40(a), 41(b) and 70. Supporting data is located in Attachments C through K. HHSC routinely reviews various measures related to network adequacy, including those reported in the following section of this report: provider network counts, geo-access and out-of-network utilization. HHSC monitors these measures in combination with member complaints in order to assess the adequacy of MCO provider networks.

A. PROVIDER NETWORKS

This subsection includes quarterly healthcare and pharmacy provider counts for STAR and STAR+PLUS and dental provider counts for the Dental Program. The provider network

methodology is contained in Attachment C1, provider network counts are reported in Attachment C2, and provider termination counts are reported in Attachment C3.

1. Primary Care Providers (PCPs)

MCOs are required to assign 100% of non-dual members to a PCP within 5 business days of MCO enrollment. The Managed Care Contracts requires all MCOs to assign members to a PCP, and for all adult members to have access to at least one PCP and children to at least two age appropriate PCPs within established mileage standards.

Across the STAR program statewide, the MCOs reported a total of 19,459 unique PCP providers, an increase of 451 (2.37%) from the prior quarter. The MCOs reported 14,818 unique PCP providers in the STAR+PLUS program statewide, an increase of 342 (2.36%) from the prior quarter.

2. Specialists (non-pharmacy)

Across the STAR program statewide, the MCOs reported 59,869 unique specialty providers, a decrease of 656 (1.08%) from the prior quarter. The MCOs reported 51,431 unique specialty providers in the STAR+PLUS program statewide, a decrease of 172 (0.33%) providers from the previous quarter.

3. Provider Terminations

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in 2016 SFQ4. The MCOs reported a variety of reasons for provider termination, including: providers failed to re-credential, termination requested by provider, MCO terminated for cause, provider left group practice, provider retired and provider closed practice.

4. Pharmacy Providers

Across the STAR program statewide, the MCOs reported a total of 4,908 unique pharmacies, a decrease of 12 (-0.24%) pharmacies from the prior quarter. The MCOs reported 4,792 unique pharmacies in the STAR+PLUS program statewide, a decrease of 30 (-0.62%) pharmacies from the prior quarter. All MCOs contract with the pharmacies outside their primary SDA to ensure members have access to a pharmacy if they travel outside the SDA.

5. Dental Program Provider Counts

In 2016 SFQ4, DentaQuest reported a total of 5,422 unique dental providers, an increase of 166 (3.16%) dental providers from the prior quarter. MCNA reported 4,718 unique dental providers, an increase of 96 (2.08%) dental providers from the prior quarter.

B. PROVIDER OPEN PANEL

This section addresses annual reporting requirements found in STC 25(e) and 41(b), regarding the number of network providers accepting new Demonstration populations. Supporting data is located in charts below. All MCOs submit monthly files to the enrollment broker identifying the number of PCPs and main dentists who are accepting new Medicaid patients, described here as "open panel" PCPs and "open practice" dentists. This section reports the open panel percentage for the overall provider network; section D of the report includes open panel data as a geoaccess measure. 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.

The open panel PCP standard is a benchmark and the state routinely monitors additional measures discussed in this section of the report as indicators of network adequacy.

Even though the open panel rates for certain MCOs or service delivery areas do not meet the 80% benchmark, MCOs are required to assign 100% of non-dual eligible members to a PCP within five business days of MCO enrollment.

1. STAR and STAR+PLUS Statewide

Across the STAR program, open panel PCP rates remained steady above the 80% benchmark in 2016 SFQ4. Across the STAR+PLUS program, the open panel PCP rate remained steady above the 80% benchmark.

2. STAR and STAR+PLUS by SDA

Throughout 2016 in the STAR program, all of the service delivery areas maintained high open panel PCP rates. In the STAR+PLUS program, open panel PCP rates fell below the 80% benchmark in at least one quarter in MRSA Central, and Travis counties. Notable service delivery areas with open panel PCP rates at 94% or higher throughout 2016 included STAR: El Paso, Hidalgo and Nueces and STAR+PLUS: El Paso, Hidalgo, MRSA Northeast and Nueces.

3. STAR and STAR+PLUS by MCO

Broken down by MCO, most open panel PCP rates remained relatively stable throughout 2016. MCO performance remained consistent across all quarters in 2016. Most MCOs in the STAR program exceeded the open panel PCP rates at 90% or higher throughout 2016 with the exception of Cook Children's and Texas Children's. Cook Children's Health Plan failed to meet

the 80% standard due to difficulties experienced with provider files. HHSC advised Cook to contact the enrollment broker to ensure that files sent were received. Although Cook Children's did not meet the benchmark for 80% of PCPs with open panels in FY2016, the plan contracts with several PCPs that elect to maintain a closed panel. These in-network PCPs agree to accept new patients, which is normally achieved on a case-by-case basis. Texas Children's Health Plan failed to meet the benchmark by a small margin between 78 and 79% in SFQ1 - SFQ2 and SFQ4. Seven STAR MCOs (STAR Blue Cross Blue Shield, Christus, Driscoll Children's, El Paso First, Parkland, Seton and United) and one STAR+PLUS MCO (United) far exceeded the standard throughout 2016, with open PCP rates at 94% or higher.

In the STAR+PLUS program all plans met or exceeded the 80% benchmark.

4. Dental Program

Both dental plans met the state's 90% benchmark for main dentists with open practices in every fiscal quarter of 2016.

Provider Open Panel by MCO					
Program	MCO Name	Q1	Q2	Q3	Q4
STAR	Aetna	93.8%	92.9%	93.3%	93.7%
	Amerigroup	86.7%	86.8%	86.8%	86.8%
	BCBS	91.2%	92.3%	92.3%	94.6%
	CHC	91.4%	91.4%	91.8%	91.6%
	Christus	100.0%	100.0%	100.0%	100.0%
	Community First	91.8%	91.9%	91.8%	91.9%
	Cook Children's	62.7%	63.9%	63.4%	64.2%
	Driscoll Children's	98.1%	98.0%	98.2%	98.1%
	El Paso First	96.1%	96.2%	96.4%	97.0%
	FirstCare	87.2%	87.4%	87.4%	90.7%
	Molina	91.3%	91.5%	91.6%	92.4%
	Parkland	94.2%	94.5%	94.6%	94.7%
	Scott & White	92.4%	90.4%	89.5%	89.0%
	Sendero	93.4%	94.1%	94.1%	93.9%
	Seton	100.0%	100.0%	100.0%	100.0%
	Superior	83.5%	84.6%	84.5%	84.7%
	Texas Children's	77.9%	79.2%	80.2%	79.4%
	United	94.4%	93.9%	94.1%	94.5%
STAR+PLUS	Amerigroup	85.0%	85.3%	85.1%	85.1%

	Cigna-HealthSpring	91.6%	91.8%	91.8%	91.2%
	Molina	90.4%	90.5%	89.6%	90.9%
	Superior	80.9%	82.1%	82.0%	82.0%
	United	95.2%	94.3%	94.2%	94.8%

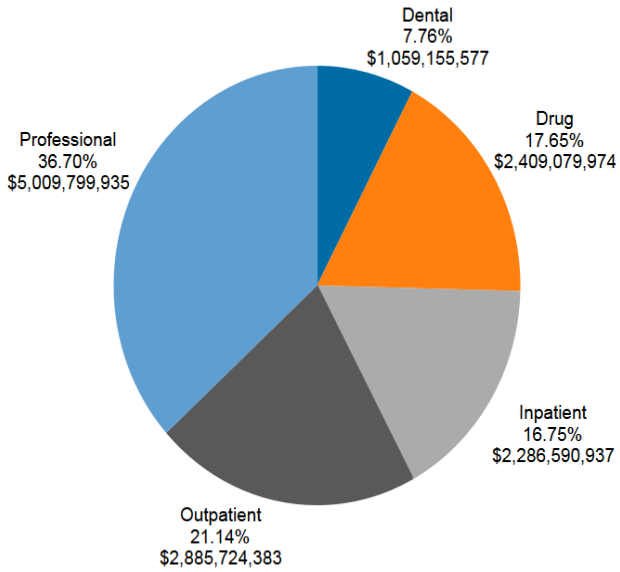
Provider Open Panel by SDA					
Program	SDA	Q1	Q2	Q3	Q4
STAR	Bexar	92.4%	91.6%	91.4%	91.5%
	Dallas	91.9%	91.5%	91.7%	91.5%
	El Paso	97.7%	97.9%	98.1%	98.5%
	Harris	93.8%	94.0%	93.7%	94.1%
	Hidalgo	97.5%	97.3%	97.4%	97.2%
	Jefferson	93.6%	93.8%	93.7%	93.8%
	Lubbock	93.3%	93.0%	92.9%	93.1%
	MRSA Central	83.3%	83.7%	83.4%	83.7%
	MRSA Northeast	87.7%	87.5%	87.3%	87.5%
	MRSA West	87.2%	87.3%	87.2%	88.0%
	Nueces	97.2%	97.2%	97.0%	96.7%
	Tarrant	90.3%	88.7%	88.9%	89.2%
	Travis	93.2%	93.5%	93.3%	93.5%
STAR+PLUS	Bexar	81.9%	82.6%	83.6%	84.1%
	Dallas	81.1%	81.5%	82.1%	82.8%
	El Paso	97.2%	97.2%	97.2%	97.0%
	Harris	93.0%	93.3%	93.1%	93.3%
	Hidalgo	97.1%	97.1%	97.3%	97.5%
	Jefferson	92.2%	92.6%	92.7%	92.8%
	Lubbock	93.2%	92.4%	92.1%	91.3%
	MRSA Central	78.0%	80.8%	80.4%	80.8%
	MRSA Northeast	98.0%	95.6%	95.6%	95.2%
	MRSA West	90.3%	90.4%	90.5%	90.2%
	Nueces	95.8%	95.7%	95.5%	95.3%
	Tarrant	85.4%	85.0%	84.5%	84.0%
	Travis	74.7%	75.0%	74.9%	76.7%

C. SERVICE UTILIZATION

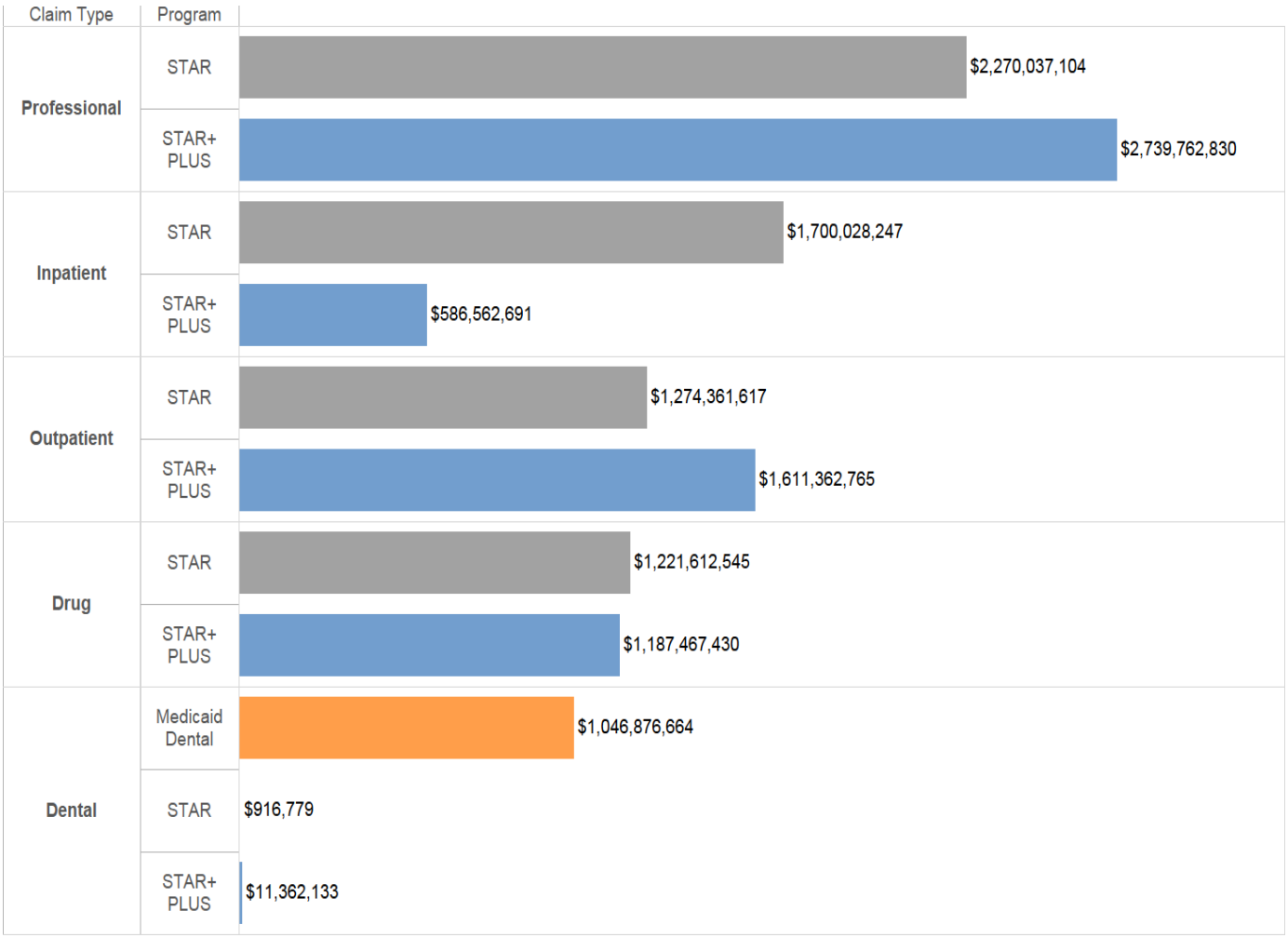
This subsection addresses annual reporting requirements found in STC 25(e). Analysis of service utilization is based on the completed year SFY 2015 for acute care services and pharmacy services and based off encounter data. Long term services and supports are not included and expenditures represent the amount the MCO reimbursed the provider.

Depicted in the figures below, professional claims made up over 36.70% of the total expenditures in STAR and STAR+PLUS in SFY 2015. "Inpatient" refers to inpatient hospital services and "outpatient" refers to services received at a hospital on an outpatient basis and at non-hospital facilities. Professional claims account for about one-third of expenditures. For professional, pharmacy, in-patient and outpatient, the STAR program overall spent more than STAR+PLUS while STAR+PLUS spent slightly more than STAR on professional and outpatient claims.

Expenditures by Claim Type (2015)

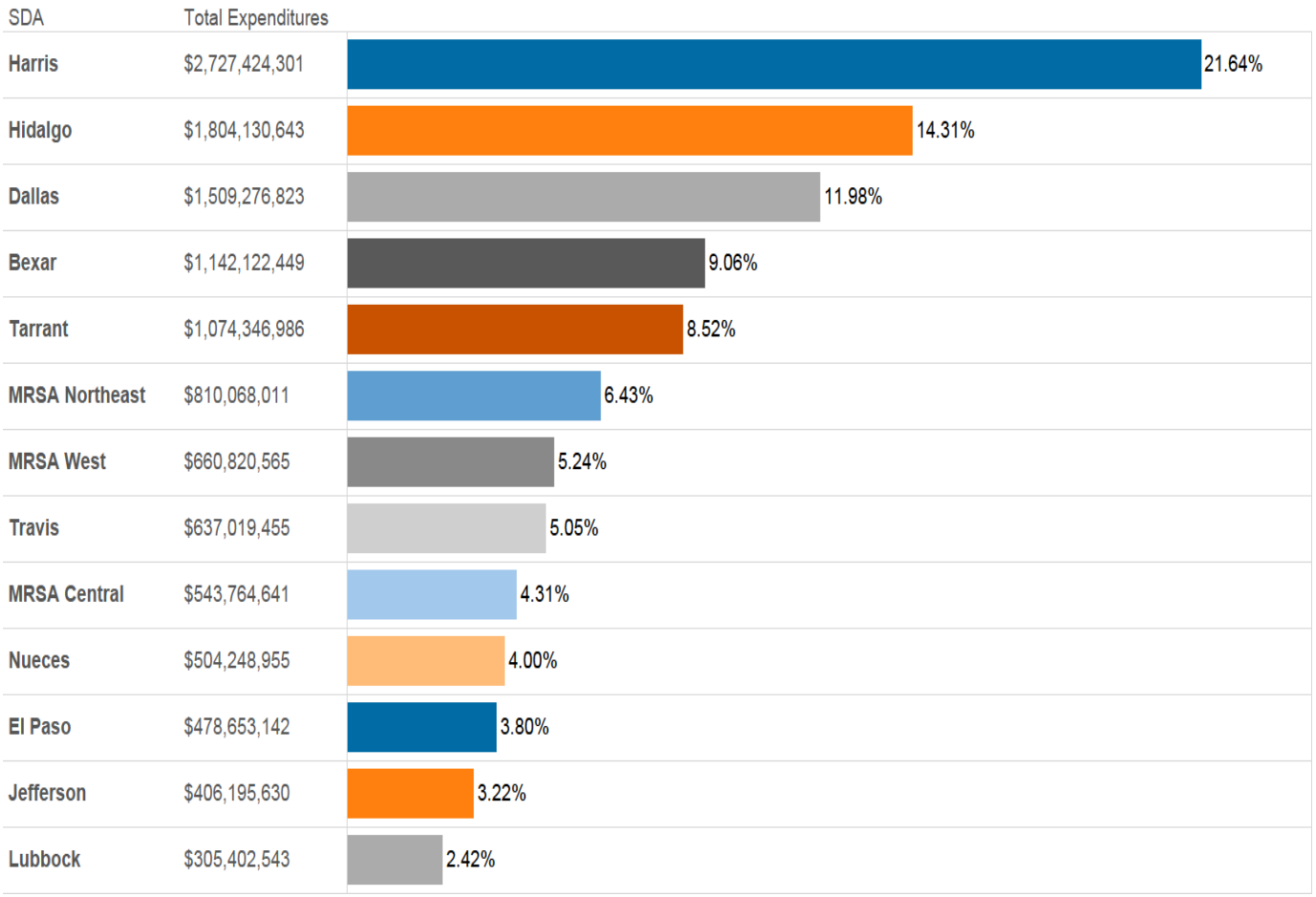


Expenditures by Program and Claim Type (2015)



The figure below shows percentage of expenditures by SDA.

Expenditures by SDA (2015)



Compared to average monthly enrollment market share, average monthly expenditures as a percentage by MCO and program were fairly consistent, reflected in the figures below. In the STAR program, Superior, Amerigroup, Texas Children's Community Health Choice, Community First, Parkland, Driscoll, United, FirstCare and Molina's Aetna, average monthly expenditures as a percent by MCO slightly exceeded their average monthly enrollment market share all by less than 2%. In the STAR+PLUS program, Superior and Amerigroup's average monthly expenditures as a percent by MCO exceeded their average monthly enrollment market share by less than 5%. DentaQuest's average monthly dental expenditures as a percent by MCO was about 2% higher than their average monthly enrollment market share.

Average Monthly STAR Enrollment and Expenditures by SDA (2015)

SDA	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Harris	688,119	23.39%	$127,528,087	23.66%
Hidalgo	363,030	12.34%	$66,810,713	12.40%
Dallas	412,955	14.04%	$70,796,131	13.14%
Tarrant	270,328	9.19%	$48,180,417	8.94%
Bexar	251,622	8.55%	$47,887,744	8.89%
MRSA Northeast	166,526	5.66%	$29,694,426	5.51%
MRSA West	146,917	4.99%	$25,457,165	4.72%
Travis	150,400	5.11%	$28,493,241	5.29%
MRSA Central	129,107	4.39%	$22,619,297	4.20%
El Paso	127,838	4.35%	$20,570,753	3.82%
Nueces	83,790	2.85%	$20,306,666	3.77%
Lubbock	75,712	2.57%	$14,313,857	2.66%
Jefferson	75,031	2.55%	$16,254,527	3.02%

Average Monthly STAR+PLUS Enrollment and Expenditures by SDA (2015)

SDA	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Harris	106,958	19.86%	$99,757,271	19.51%
Hidalgo	72,543	13.47%	$83,533,507	16.34%
Dallas	62,676	11.64%	$54,976,937	10.75%
Bexar	50,494	9.38%	$47,289,127	9.25%
MRSA Northeast	42,873	7.96%	$37,811,242	7.39%
Tarrant	38,597	7.17%	$41,348,499	8.09%
MRSA West	35,910	6.67%	$29,611,215	5.79%
MRSA Central	26,765	4.97%	$22,694,424	4.44%
Nueces	21,499	3.99%	$21,714,080	4.25%
Travis	24,151	4.48%	$24,591,714	4.81%
El Paso	23,911	4.44%	$19,317,009	3.78%
Jefferson	19,252	3.57%	$17,595,109	3.44%
Lubbock	12,895	2.39%	$11,136,355	2.18%

Average STAR Monthly Expenditures by Program and MCO (2015)

MCO Name	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Superior	704,945	23.97%	$129,233,201	23.98%
Amerigroup	575,790	19.58%	$92,414,656	17.15%
Texas Children's	332,978	11.32%	$59,115,374	10.97%
CHC	236,875	8.05%	$50,486,856	9.37%
Parkland	185,418	6.30%	$33,298,726	6.18%
Driscoll Children's	134,159	4.56%	$29,195,655	5.42%
United	119,763	4.07%	$25,131,611	4.66%
Community First	110,150	3.74%	$20,173,144	3.74%
FirstCare	95,048	3.23%	$18,339,771	3.40%
Molina	103,437	3.52%	$18,095,991	3.36%
Cook Children's	100,078	3.40%	$18,007,981	3.34%
Aetna	74,904	2.55%	$14,305,557	2.65%
El Paso First	65,527	2.23%	$11,133,349	2.07%
Scott & White	41,551	1.41%	$7,508,786	1.39%
BCBS	24,360	0.83%	$5,165,107	0.96%
Sendero	12,308	0.42%	$3,031,831	0.56%
Seton	17,003	0.58%	$2,830,484	0.53%
Christus	7,084	0.24%	$1,444,945	0.27%

Average STAR+PLUS Monthly Expenditures by Program and MCO (2015)

MCO Name	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
Superior	146,447	27.19%	$142,208,021	27.81%
Amerigroup	140,681	26.12%	$130,396,431	25.50%
United	107,732	20.01%	$103,713,906	20.28%
Molina	94,708	17.59%	$86,708,602	16.96%
Cigna-HealthSpring	48,956	9.09%	$48,349,527	9.45%

Average Dental Monthly Expenditures by MCO (2015)

MCO Name	Monthly Average Number of Clients Utilizing Services	Monthly Average Expenditure	% of Total - Monthly Average Expenditure
DentaQuest	192,491	$49,851,175	57.14%
MCNA	170,510	$37,387,745	42.86%
Delta	13	$1,373	0.00%

D. GEOACCESS

This subsection includes quarterly geo-access information based on geo-mapping data provided by HHSC Strategic Decision Support (SDS) and self-reported by MCOs, in accordance with STCs 25(e) and 40(a).

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

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

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

- All STAR and STAR+PLUS members: open panel PCPs, obstetrician/gynecologist for female members, orthopedic surgeon, outpatient behavioral health services, acute care hospitals and pharmacy;
- Adults and children in STAR and children in STAR+PLUS: orthopedic surgery;
- Children in STAR and STAR+PLUS: ENT;
- Adults in STAR+PLUS: urology, ophthalmology, cardiovascular disease specialist;
- Dental members: main dentists, endodontic, oral surgery, orthodontic; periodontist and prosthodontist.

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

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

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

1. Access to PCPs and ENTs

Geoaccess to PCPs and ENTs is reported on Attachment E. In 2016 SFQ4 across the state, the STAR and STAR+PLUS programs exceeded the State's 90% benchmarks for access to PCPs and ENTs. Based on the HHSC Geo-Mapping results, all plans met the access standard for children and adult access to a PCP with an open panel in 2016 SFQ4. Most plans met the access standard for children's access to an ENT with an open panel in 2016 SFQ4. The following plans did not meet the 90% ENT access standard:

STAR: MRSA West: Amerigroup, First Care and Superior; STAR+PLUS: MRSA West: Amerigroup and Superior.

2. Access to Specialty Care

Attachments I1 and I2 show the geo-access measures by MCO for specialty care. The attachments are separated by children and adults and by the STAR and STAR+PLUS programs.

Children

Most STAR MCOs met the geomapping standards for providing specialty care to child members with the exception of the following MCOs listed by SDA: MRSA West (Amerigroup) and (First Care), and Jefferson (Molina).

In the STAR+PLUS, program, Amerigroup in MRSA West and Molina Jefferson SDAs experienced difficulty with achieving the geomapping standards for providing specialty care to children.

Adults

In the adults' category of the STAR program, the majority of the MCOs met the geomapping standards for providing specialty care. However, the following STAR plans failed to meet the standards by SDA: MRSA West (Amerigroup) and (First Care) and El Paso (Superior). In the STAR+PLUS program the following plans failed to meet the standards by SDA: Jefferson (Molina) and MRSA West (Amerigroup).

HHSC granted a special exception request in the children and adult's categories for the following STAR plan: First Care (MRSA West) through 2017 SFQ1. In STAR+PLUS, a special exception request was given to Molina in the Jefferson SDA through SF16 Q4. Special exception requests are pending for the following STAR MCOs: Amerigroup MRSA West and Superior El Paso.

3. Access to Pharmacy

Attachment G provides summaries of HHSC geo-mapping data by plan and SDA for pharmacies. For all STAR and STAR+PLUS SDAs, the following benchmarks applied:

- 80% – access to a network pharmacy in urban counties within 2 miles
- 75% – access to a network pharmacy in suburban counties within 5 miles
- 90% – access to network pharmacy in rural counties within 15 miles
- 90% – access to a 24-hour pharmacy in all counties within 75 miles

Certain areas continued to have deficiencies in meeting access standards in 2016 SFQ4. This information is available in Attachment G. It is important to note that 100% of members have access to mail order pharmacies; this serves as an important accessibility benefit for both members who require maintenance medications to manage chronic health conditions and for members who lack access to transportation.

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

4. Dental Geo-mapping

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

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

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

In 2016 SFQ4, both DentaQuest and MCNA maintained sufficient provider networks for main dentists in rural and urban counties as well as pediatric dentists statewide with the exception of the Upper Rio Grande region due in part to overall provider shortages in these areas. Access to dental specialty providers (periodontists, endodontists and prosthodontists) is limited in some parts of Texas as depicted in Attachment H. It should be noted that statewide data from Attachment H indicates both DMOs have experienced extreme difficulty procuring prosthodontists within 75 miles. Both DMOs report monitoring the State Licensing Board's and HHSC claims administrator's websites and utilizing other internet resources in an effort to identify potential recruitment opportunities.

E. PROVIDER 24/7 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. This section fulfills the annual reporting requirement of STC 40(c), MCO compliance with access to providers 24 hours a day, 7 days a week (24/7). The managed care contracts outline accessibility and availability requirements, including access to emergency and behavioral health services; access to PCPs 24 hours a day, 7 days a week; and appointment availability and wait times.

According to the managed care contracts, MCOs must ensure compliance with provider 24/7 accessibility through their provider networks. HHSC recently requested the results of each MCO's efforts to systematically evaluate continuous access to PCPs in 2016.[1]

1. General Emergency Services

According to the managed care contracts, emergency services must be provided to members without regard to prior authorization or the provider's contractual relationship to the MCO, and general patterns of access are addressed in the out-of-network section of this report.

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[1] Uniform Managed Care Terms and Conditions (UMCC) 8.1.3 and 8.1.4
See also Title 28 of the Insurance code, Rule 11.1607 that a sufficient number of PCPs be available and accessible 24 hours per day, seven days per week within an HMO's service delivery area.

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 business days after receipt of reasonably requested documentation.

2. Pharmacy

According to the managed care contracts, MCOs must guarantee access to at least one 24-hour pharmacy within 75 miles for adult and children members. In 2016 SFQ4, most MCOs in most service delivery areas met the geoaccess standard in STAR and STAR+PLUS (see Attachment J). The service delivery areas that did not meet the access standard can be viewed in Attachment J.

3. Behavioral Health

According to the managed care contracts, the MCOs must have a toll-free hotline to handle routine, emergency, and crisis behavioral health calls. The hotline must be available 24 hours a day, 7 days a week. MCOs are required to meet and report hotline performance standards to HHSC each quarter (see Attachments M1 - M4). More information is provided in the Consumer Issues section listed under the Hotline Call Volume and Performance subsection.

4. Twenty-four Hour PCP Access

HHSC requires MCOs to make best efforts to ensure that PCPs are accessible 24 hours per day, 7 days a week and outlines very specific criteria for what constitutes compliance in the managed care contracts. For example, providers must offer after-hours telephone availability through an answering service, recorded messages with contact information for on-call PCP, or call forwarding that routes the caller to the on-call PCP or an alternate provider.

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. MCOs are surveyed on a quarterly, semiannual or annual basis to assess compliance for 24/7 and after-hours provider accessibility. MCOs utilize methods including computer - assisted telephone interviews, telephone surveys (non-computerized), mailed surveys, monthly secret shopper calls and face-to-face provider visits to measure provider accessibility compliance with the HHSC contractual standards. Provider Compliance rates for 24/7 accessibility ranged from 33% to 100%. Providers who are not in compliance with HHSC's contractual standards receive phone calls or letters detailing the contractual requirements and are subject to remediation methods including mailed provider re-education letters regarding the managed care contractual standards, follow-up surveys, face-to-face re-education (e.g. evaluating/coaching

provider staff) and unscheduled calls to providers to reassess compliance. If despite these interventions providers do not achieve compliance, additional efforts corrective actions including performance improvement projects (PIPs) leading up to provider contract termination.

5. External Quality Review Organization (EQRO) Member Satisfaction Surveys

Currently, the most recent EQRO member satisfaction survey has not been approved by HHSC. HHSC will provide an update when the report is finalized.

OUT-OF-NETWORK UTILIZATION

As required by Texas law,[2] the State monitors health and dental plans' use of out-of-network (OON) facilities and providers.[3] In each SDA, OON utilization should not exceed the following thresholds:

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

1. SFQ4 2016

Attachment D details the OON utilization rates by program, MCO and SDA. The following plans listed below exceeded OON utilization standards in 2016 SFQ4, HHSC approved special exception requests from MCOs listed below. The State will continue to monitor these plans and will require corrective action or other remedies if appropriate.

STAR

- Aetna: Bexar and Tarrant SDA
- Amerigroup: Dallas and Harris SDAs
- Molina: Dallas and Jefferson SDAs
- Seton: Travis SDA
- Texas Children's: Harris SDA

[2] Texas Government Code §533.005(a)(11).
[3] 1 Texas Administrative Code §353.4(e)(2).

STAR+PLUS

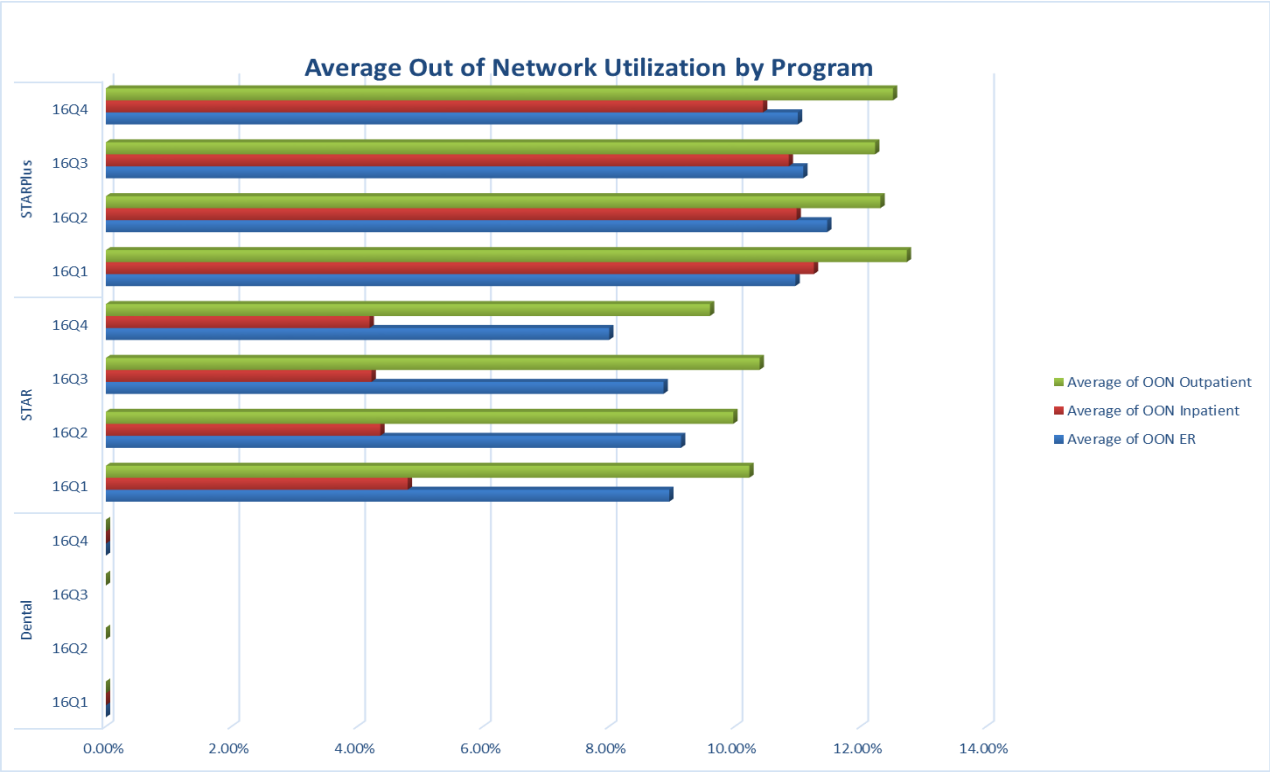
- Amerigroup: Harris SDA
- Cigna Health-Spring: Tarrant SDA
- Molina: Dallas and Harris SDAs
- Superior: Dallas SDA

HHSC approved special exception requests from MCOs listed above with the exception of Aetna Bexar and Tarrant SDAs. The State will continue to monitor these plans and will require corrective action or other remedies if appropriate. A description of the special exception request process is detailed below.

Dental plans continued to report OON utilization well below the 20% threshold at 0% for 2016 SFQ4. In the Dental Program, the 20% standard for "other services" applies to out-of-network dental services.

2. SFQ1 through SFQ4 of 2016

Analysis of the 2016 OON data revealed that, among STAR MCOs/SDAs, the average outpatient OON usage (-0.03%) dipped slightly in 2016 SFQ4, while inpatient (-0.87%) and outpatient (-0.79%) OON utilization rates (decreased marginally from SFQ3 to SFQ4). In the STAR+PLUS program, the average ER (-.09%) and inpatient (-0.41%) decreased while the outpatient OON (0.28%) usage among STAR+PLUS MCOs/SDAs increased from SFQ3 to SFQ4.The graph below includes the average ER, outpatient and inpatient utilization rates among the STAR and STAR+PLUS programs. The tables identify that during SFY2016, the average outpatient OON was the largest in all four quarters for both the STAR and STAR+PLUS programs.



3. Special Exception Request Process

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

IV. OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

This section addresses the quarterly requirements for STC 70 regarding outreach and other initiatives to ensure access to care. The Dental Stakeholder Update addresses STC 41(c) and the Medicaid Managed Care Advisory Committee meeting update also addresses STC 70.

A. ENROLLMENT BROKER AND PLAN ACTIVITIES

The State's Enrollment Broker, MAXIMUS, performs various outreach efforts to educate potential clients about their medical and dental enrollment options. During the 2016 D5 Demonstration period (October - December 2016) MAXIMUS sent 307,365 enrollment mailings to potential STAR and STAR+PLUS clients, and 209,665 mailings to potential Dental Program clients. MAXIMUS field staff completed 18,817 home visit attempts for these programs and 209,508 phone call attempts. Additionally, MAXIMUS completed 5,192 field events, which included enrollment events, community contacts, presentations, and health fairs. The full report is available in Attachment L.

The State's managed care contracts also require health and dental plans to conduct provider outreach efforts and educate providers about managed care requirements. Plans must conduct training within 30 days of placing a newly contracted provider on active status. Training topics that promote access to care include:

- Covered services and the provider's responsibility for care coordination;
- The plan's policies regarding network and OON referrals;
- Texas Health Steps benefits; and
- The State's Medical Transportation Program.

To promote access to care, health and dental plans must update their provider directories on a quarterly basis and online provider directories at least twice a month. Plans also must mail member handbooks to new members no later than five days after receiving the State's enrollment file and to all members at least annually and upon request. The handbooks must describe how to access primary and specialty care.

Through the member handbooks and other educational initiatives, plans must instruct members on topics such as:

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

B. DENTAL STAKEHOLDER MEETING

On July 15, 2016, HHSC participated in a quarterly meeting between the Texas Dental Association (TDA) and the dental maintenance organizations (DMOs). The meeting focused on policy and operational issues. In addition, HHSC's Dental Director attended two Texas Health Steps regional trainings in Midland and Laredo, Texas in August 2016. The Dental Director attended the meetings to provide information to providers and answer questions.

C. MEDICAID MANAGED CARE ADVISORY COMMITTEE

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

The SMMC did not meet in August 2016 as expected. However, as stated in the previous quarterly report, part of the process called for in Senate Bill (S.B.) 200, approved by the 84th Texas Legislature, allowed the HHS Transformation Office to establish a workgroup to review and draft rules pertaining to advisory committees that are either new or are being reestablished. HHSC posted the rules to the Texas Register April 15, 2016. From April 1st 2016 to June 30th 2016, applicants for SMMCAC were solicited. Appointments to the committee were made by the executive commissioner and the committee met in October of 2016 (which will be further discussed in the 1115 Q1 2017 Managed Care Report).

D. PUBLIC FORUM

In accordance with STC 14, Post Award Forum, HHSC afforded the public with an opportunity to provide comments on the progress of the Demonstration.

The Medical Care Advisory Committee (MCAC) met on August 11th, 2016. The date, time and location of the MCAC were published on the HHSC website prior to the meeting. The Associate Commissioner for Medicaid and Children's Health Insurance Program (CHIP) Services, explained that the Transformation waiver serves three purposes in Texas. First, it is the vehicle for establishing statewide managed care; secondly, it operates as the vehicle for establishing the Delivery System Reform Incentive Payment (DSRIP) structure, and finally, the Uncompensated Care pool is operated under the waiver. HHSC is in the fifth year of the 1115 Waiver and in May of 2016 received a 15-month extension from CMS to extend through the 6th year. HHSC is currently working with CMS on obtaining a longer term extension. A statewide learning collaborative meeting for DSRIP providers occurred on August 30th and 31st and managed care representatives were also invited to attend. The internal transformation process is ongoing and the new structure is scheduled to go live September 1st. Staff from various departments will be transitioned into the Medicaid and Social Services Division. Four coordinated departments with new leadership have been structured.

Additionally, the Network Access Improvement Program (NAIP) and the implementation for STAR Kids were discussed. It was explained that the last components of the managed care roll out is the STAR Kids program. It is focused on children who are 20 years old or younger. The three major components of the STAR Kids product line include the comprehensive strengths based needs assessment, person centered planning and service design as well as ongoing service coordination.

Members of the MCAC provided comments and questions related to the new direction for DSRIP projects. No members of the public provided comment during the meeting.

E. INDEPENDENT CONSUMER SUPPORTS SYSTEM PLAN

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

1. Office of the Ombudsman

Compared to the third quarter of 2016, the Ombudsman Managed Care Assistance Team (OMCAT) averaged a call abandonment rate of eight percent. And although there was a call volume decrease of two percent or 211 fewer calls, there was an increase of calls handled of four percent or 359 calls. The increase in calls handled was due to two staff members returning to work after being out for an extended period of time. The unit does not anticipate a significant change in the call volume until the fall of 2016 when the STAR Kids program rolls out. The OMCAT unit continued to direct a managed care support network to better coordinate assistance provided to Medicaid managed care clients as mandated by the state legislature. The network of entities includes the Ombudsman Office, the Long Term Care Ombudsman, the HHSC Medicaid/CHIP Division, Area Agencies on Aging, and Aging and Disability Resource Centers. The network facilitated three monthly meetings over the fourth quarter and will continue to hold monthly meetings into the first quarter of the next fiscal year (FY17). The network identified several issues that prevented clients from accessing managed care services and has been working on resolving as well as preventing those issues from reoccurring. The unit worked with the Department of Aging and Disability Services (DADS) and Texas Legal Services Center to develop and finalize a curriculum of customized Medicare training for the entire Ombudsman Office and will deliver that training in the first quarter of SFY17. Access to prescriptions continued to be the top reason for complaints and were one fourth of all complaints received during the quarter. Many of these complaints related to clients not showing in the MCO's PBM or clients whose Medicaid was recently renewed and not showing in the MCO's system at all.

1. Aging and Disability Resource Center (ADRC)

Local-level ADRC staff continue to participate in training activities about available resources and referral protocols. Training sessions conducted this quarter included information on the STAR Kids program, the Office of the Ombudsman, and the Texas Department of Housing and Community Affairs (TDHCA) Section 811 Project Rental Assistance program and an overview of other TDHCA programs. ADRCs also received training on the Minimum Data Set 3.0 Section Q and its application to the Local Contact Agency program. The following are the dates and training topics:

- July 19: The Health and Human Services Commission Transformation and how it impacts the ADRC program; the Fiscal Year 2017 ADRC Contract Scope of Work; and travel policies and guidelines.
- August 31: TDHCA Section 811 Project Rental Assistance program, other TDHCA programs, and the TDHCA website
- September 27: STAR Kids and an overview of the Office of Ombudsman
- September 29: Minimum Data Set 3.0 Section Q and Best Practices for Local Contact Agency.

On July 18, 2016, the ADRC Advisory Committee held its first meeting with the members appointed by Department of Aging and Disability Services Commissioner Jon Weizenbaum. Committee members were provided information on the ADRC Three-Year Strategic Plan, the Advisory Committee bylaws, and Robert's Rules of Order. The Advisory Committee elected Brian Cavuto as Chair. Mr. Cavuto is a licensed Home and Community Support Services Agency Administrator and currently works for Family Eldercare.

F. HHSC MANAGED CARE INITIATIVES

During the December 2016 1115 monthly monitoring call, HHSC provided to CMS an overview of the upcoming changes to network adequacy analysis in managed care and how the changes (CMS rules and Senate Bill (SB)760) will change 1115 report structure and methodology for the upcoming March 2017 SFQ3 1115 report.

SB760 and new rules issued by the CMS require HHSC to establish minimum access standards, including time and distance standards, for MCO provider networks for specific provider types. SB 760 and CMS rules authorize HHSC to establish standards that take Texas' geographic diversity and Medicaid population into account when developing standards. HHSC is also required to monitor MCOs compliance with established standards and to publish standards on the agency's website.

HHSC continues to focus its efforts to address the access requirements of both the CMS rules and SB760 and on completing various activities required prior to the implementation of the SB760 requirements in March 2017.

In March 2014 a new federal rule became effective governing HCBS setting requirements, including individuals' right to privacy, dignity, respect, community integration, access to competitive employment and optimization of individual choices concerning daily activities, physical environment and social interaction. The new rule also includes expectations governing how states implement person directed planning. All states are required to submit a transition plan outlining the steps they will take to come into compliance with the regulations by 2019. HHSC continues to work on its transition plan and on completing the various activities required to come into compliance.

V. COLLECTION AND VERIFICATION OF ENCOUNTER DATA AND ENROLLMENT DATA.

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

The State continues to conduct the quarterly MCO encounter financial reconciliation process for 2016 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.

VI. OPERATIONAL/POLICY/SYSTEMSFISCAL DEVELOPMENTS/ISSUES

This section addresses STC 70, regarding operational issues identified during the quarter. It also addresses pending lawsuits that may potentially impact the Demonstration, and new issues identified during the reported quarter.

A. UPDATE FROM PRIOR QUARTER

HHSC has not identified any ongoing issues in the relevant subject matter sections of this report.

B. LITIGATION UPDATE

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

Legacy Community Health Services, Inc., v. Janek (official capacity) and Texas Children's Health Plan. Filed on January 7, 2015, in the U.S. District Court for the Southern District of Texas. Plaintiff Legacy is a Federally Qualified Health Center (FQHC) and a Medicaid provider that was in Texas Children's Health Plan's (TCHP's) provider network. TCHP notified Legacy in December 2014 that Legacy was to be terminated as a provider in TCHP's plan. Legacy brought suit against both TCHP and HHSC's Executive Commissioner, alleging that HHSC's method of paying FQHCs is contrary to federal law. Legacy alleges first, that the State's process for providing reimbursement for services rendered to out-of-network patients allegedly violates the Medicaid Act, 42 U.S.C. § 1396b(m)(2)(A)(vii), and, second, that the State's delegation of its reimbursement responsibility to third-party Managed Care organizations allegedly violates the Act, id. § 1396a (bb)(5)(A). Plaintiff seeks injunctive relief under 42 U.S.C. § 1983 to remedy the alleged shortcomings in Texas's method for providing payments to Legacy for Medicaid services. FQHCs are guaranteed an encounter rate calculated under a methodology prescribed under 42 U.S.C. §1396a (bb). HHSC ensures compliance with this provision by requiring MCOs to pay FQHCs the full encounter rate, and includes funds for such payments in the capitated rate paid to MCOs. Legacy asserts that HHSC must make supplemental ("wrap") payments directly to FQHCs. District Judge Keith Ellison conducted a hearing on January 28, 2015, and denied Legacy's request for a preliminary injunction. Legacy non-suited TCHP, but continues to maintain its claims against HHSC.

Both Legacy and HHSC filed motions for summary judgment and on May 3, 2016, the court ruled in favor of Legacy on the "wrap payment" portion of the case, finding that HHSC improperly delegated to the managed care organizations (MCOs) the responsibility of ensuring that the FQHCs receive their full encounter rate. The court also ruled that CMS approval of the State Plan Amendment authorizing this payment methodology was arbitrary and capricious and asked CMS to file an advisory with the court concerning the issues in the case. CMS filed a Statement of Interest with the court on July 25, 2016 asserting that the payment methodology used by HHSC comports with federal law. On September 2, 2016, the court issued a final order, ruling that HHSC's "emergency services" language was in compliance with section 1396b(m)(2)(A)(vii) of the Medicaid Act, but that section 1396a(bb) requires the state to reimburse FQHCs for all Medicaid-covered services, both in-network and out-of-network services, regardless of whether the out-of-network services meet the requirements of § 1396b(m)(2)(A)(vii). HHSC filed a notice of appeal with the U.S. 5th

Circuit Court of Appeals on October 13, 2016.

Texas Children's and Seattle Children's Hospital v. Burwell (official capacity), Tavenner (official capacity), and CMS. Filed on December 5, 2014, in the U.S. District Court for the District of Columbia. District Judge Emmet Sullivan granted a preliminary injunction request by Plaintiffs, and required CMS to discontinue enforcing its policy published as "FAQ Number 33" and involving the inclusion of revenues associated with patients having coverage under both Medicaid and private insurance. The court also expressly prohibited CMS from taking action to recoup past Disproportionate Share Hospital (DSH) program overpayments based on a state's compliance with FAQ No. 33.

HHSC notes that the same issue was litigated in state court. In 2013, Texas Children's Hospital (TCH) sued HHSC in state court alleging that by following CMS's FAQ 33, HHSC had improperly altered its method of calculating uncompensated care, adversely affecting TCH's disproportionate share and uncompensated care payments. That lawsuit was dismissed on March 29, 2014. However, TCH and co-plaintiff Seattle Children's now assert substantially the same theory against CMS in federal court litigation. Although HHSC is not a direct party to this federal litigation, HHSC recognizes that the outcome of this case could have a significant bearing on the hospital disproportionate share and uncompensated care payment programs. Until the issue is resolved with clarity, the litigation may result in delays and uncertainty concerning the appropriate method of making the uncompensated care calculations for future payments and for recouping past DSH and uncompensated-care overpayments.

Filed in 1993, *Frew, et al. v. Smith, et al*. (commonly referred to as *Frew*), was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. The class action lawsuit alleged that the Texas EPSDT program did not meet the requirements of the federal Medicaid Act. The Texas EPSDT program, known as Texas Health Steps (THSteps), provides comprehensive and preventive medical and dental services for children through age 20 enrolled in Medicaid. The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996. The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor compliance with the orders by the Texas Health and Human Services Commission (HHSC) and the Texas Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the court found the State defendants in violation of several of the decree's paragraphs. In 2007, the parties agreed to 11 corrective action orders to bring the state into compliance with the consent decree and to increase access to THSteps services. The corrective action orders touch upon many program areas, and generally

require the state to take actions intended to ensure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in many policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

In 2013, the U.S. district court vacated two of the eleven corrective action orders: (1) Check-Up Reports and Plans for Lagging Counties, and (2) Prescription and Non-Prescription Medications, Medical Equipment, and Supplies, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions. The *Frew* Plaintiffs appealed the second order (regarding Prescription and Non-Prescription Medications, Medical Equipment, and Supplies) to the Fifth Circuit Court of Appeals. On March 5, 2015, the Fifth Circuit affirmed the district court's order vacating the corrective action order and related paragraphs of the consent decree, holding that the state had satisfied its obligations related to training Medicaid-enrolled pharmacists about EPSDT-covered pharmacy items. In February 2016, the U.S. Supreme Court denied the *Frew* Plaintiffs' petition for writ of certiorari seeking to have the Fifth Circuit's order reversed.

In 2014, the parties jointly agreed to vacate a corrective action order related to Toll-Free Numbers, and the related paragraph of the consent decree, for several Medicaid-related toll-free lines operated by the state and its contractors. The district court granted the parties' joint motion and vacated the toll-free numbers orders for all but one remaining helpline: a medical transportation line operated by one of the state's full-risk broker transportation contractors.

On January 20, 2015, the district court vacated a corrective action order related to an Adequate Supply of Health Care Providers and several paragraphs of the consent decree relating to an adequate supply of healthcare providers. The Court found that the State had satisfied the terms of those orders by taking realistic and viable measures to enhance recipients' access to care through ensuring an adequate supply of healthcare providers (both primary care and specialists) by using targeted recruitment efforts, increasing reimbursement rates, and using best efforts to maintain updated lists of providers for recipients and other providers. In March 2016, the Fifth Circuit affirmed the district court's opinion vacating the decree paragraphs and most of the Adequate Supply of Health Care Providers corrective action order. The Fifth Circuit vacated and remanded to the district court for further proceedings the portion of the district court's order which held that the State had satisfied its obligation under the corrective action order to use provider assessments to identify provider "shortages" and implement corrective action based upon any shortages, because the parties and the district court did not define "shortages" correctly. Based upon the definition of "shortages" provided by the Fifth Circuit, the Fifth Circuit also vacated and remanded to the district court for further proceedings the portion of the district court's order which held that the State had satisfied its obligation under the corrective action order to have provider

payment rates sufficient to attract enough providers to serve Medicaid recipients under age 21. In May 2016, the State filed petitions for *en banc* and panel rehearing in the Fifth Circuit regarding the March 2016 panel opinion. In November 2016, the Fifth Circuit denied those petitions for rehearing.

On September 28, 2015, the district court vacated two of the remaining corrective action orders: (1) Transportation Program, and (2) Health Care Provider Training, and related paragraphs of the consent decree, after finding that the state defendants had complied with the required actions. Plaintiffs did not appeal those two district court orders.

Diana D. as next friend of KD, a child, et al v. HHSC and Traylor (official capacity). Providers of home health speech, occupational and physical therapy services and children who receive those services brought suit in August 2015, in Travis County District Court seeking declaratory and injunctive relief related to proposed rate reductions to those services. The Plaintiffs allege claims of ultra vires actions by the Commissioner in setting the new rates that the proposed rates were an invalid rule under section 2001.038 of the Government Code, and a constitutional due-course-of-law claim under article I, section 19 of the Texas Constitution. Plaintiffs were granted a temporary injunction enjoining HHSC from implementing the new rates pending resolution of their claims. On April 21, 2016, just prior to a trial on the merits, the 3rd Court of Appeals reversed the trial court and dismissed all the plaintiffs' claims for lack of jurisdiction and vacated the temporary injunction. The Plaintiffs appealed to the Texas Supreme Court, but on September 23, 2016, the Texas Supreme Court denied Plaintiffs' request to review the case. On November 10, 2016, the 3rd Court of Appeals issued its mandate to the Travis County District Court, officially dissolving the temporary injunction and dismissing the lawsuit, and allowing HHSC to proceed with implementing the proposed rates.

C. NEW ISSUES

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

D. CLAIMS SUMMARY

This section addresses the requirements of STC 40(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% must be adjudicated within 30 days;
- 98% of appealed claims must be adjudicated within 30 days;
- 99% must be adjudicated within 90 days; and
- 98% of pharmacy claims must be adjudicated within 18 or 21 days for electronic and paper claims, respectively.

Attachments V1 - V3 are summaries of the health and dental plans' 2016 SFQ3 through SFQ4 claims adjudication results. For these quarters, STAR and STAR+PLUS MCOs reported results for acute care, behavioral health, vision services, and pharmacy claims. Additionally, STAR+PLUS MCOs also reported results for LTSS claims. Dental plans reported results for all dental claims. Both dental plans met the claim adjudication standards for clean claims in 2016 SFQ3 and SFQ4. All plans met the 98% standard for the pharmacy claims adjudicated within 18-21 days for electronic and paper claims. Almost all MCOs met the claims processing standards with some exceptions listed below. HHSC staff is in the process of developing an

appropriate remedy for the MCOs that are not in compliance with the claims adjudication standards.

STAR:

Acute Care Claims:

- Aetna: Tarrant SDA
- Amerigroup:, MRSA West and Tarrant SDAs
- Blue Cross Blue Shield: Travis SDA
- Christus: Nueces SDA
- Driscoll: Hidalgo and Nueces SDAs
- Molina: Dallas and El Paso SDAs
- Parkland: Dallas SDA
- Scott & White: MRSA Central SDA
- Sendero: Travis SDA
  Superior: Hidalgo and MRSA West SDAs

Behavioral Health Services Organization's Claims:

- Aetna: Tarrant SDA
- Amerigroup: Bexar, Harris, Jefferson, MRSA Central, MRSA West SDAs
- Scott & White: MRSA Central

Vision Services Organization's Claims

- Driscoll: Hidalgo and Nueces SDAs
- Superior: Bexar and Hidalgo SDAs
- United: Harris SDA

STAR+PLUS

Acute Care Claims:

- Amerigroup: Bexar, Lubbock, MRSA West SDAs
- Cigna-Heath Spring: Hidalgo, MRSA Northeast and Tarrant SDAs
- Molina: Bexar, Dallas, Harris, Hidalgo and Jefferson SDAs
- Superior: Bexar, MRSA West SDA
  Behavioral Health Services Organizations Claims:
- Amerigroup Bexar, Lubbock and Travis SDAs
- Cigna-Health Spring: MRSA NE SDA
  United: MRSA Central, SDA
  Vision Services Claims
- Superior: Dallas and Nueces SDAs
- United: MRSA Central, MRS NE and Nueces SDAs

Long Term Care Organization's Claims:

- Amerigroup: Jefferson, Lubbock, MRSA West and Travis SDAs
- Cigna-Health Spring: MRSA NE and Tarrant SDAs
- Molina: Harris SDA

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). Attachments R1 - R2 is a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period, 2016 SFQ1 through SFQ4.

In SFQ1 and SFQ2, MCOs forwarded 52 suspected cases of fraud, waste, or abuse to the OIG. Most of these referrals related to non-appropriate billing, program non-compliance and billing for services not rendered. OIG returned 42 of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for six cases. Dental plans forwarded seven suspected cases of fraud, waste, or abuse to the OIG. Most of these referrals related to solicitation investigations, program noncompliance, non-appropriate billing and billing for services not rendered. OIG returned six of the cases to the MCO for the determination of appropriate action.

In SFQ3 and SFQ4, MCOs forwarded 40 suspected cases of fraud, waste, or abuse to the OIG. Most of these referrals related to non-appropriate billing, program non-compliance, solicitation

billing for services not rendered. OIG returned 33 of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for seven cases. Dental plans forwarded 13 suspected cases of fraud, waste, or abuse to the OIG. Most of these referrals related to solicitation investigations, program noncompliance, non-appropriate billing and billing for services not rendered.

VII. ACTION PLANS FOR ADDRESSING ANY ISSUES IDENTIFIED

This section describes the State's action plan for addressing issues identified in the quarterly report as required by STC 70.

1. Managed Care Issues

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

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 2016 D5.

VIII. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

This section addresses the quarterly reporting requirements in STCs 51, 68 and 70 regarding financial and budget neutrality development and issues. Details on the budget neutrality calculations can be found in Attachment P.

There were no significant development issues or problems with financial accounting, budget neutrality and the CMS 64 or budget neutrality report for 2016 SFQ4.

IX. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements regarding eligible member month participants in compliance with STC 55.

Eligibility Groups Used in Budget Neutrality Calculations (2016 D5)

Eligibility Group	Month 1 (Jul 2016)	Month 2 (Aug 2016)	Month 3 (Sept 2016)	Total for Quarter Ending Sept 2016
Adults	285,178	290,602	292,028	867,808
Children	2,609,108	2,631,207	2,640,414	7,880,729
AMR	357,439	357,959	357,732	1,073,129
Disabled	424,706	424,908	421,116	1,270,730

Eligibility Groups Not Used in Budget Neutrality Calculations (2016 D5)

Eligibility Group	Month 1 (Jul 2016)	Month 2 (Aug 2016)	Month 3 (Sept 2016)	Total for Quarter Ending Sept 2016
Adults in MRSA	-	-	-	-
Foster Care	33,530	33,602	33,848	100,980
Medically Needy	131	130	130	390
CHIP-Funded	275,215	276,037	276,518	827,770
Adoption Subsidy	48,008	48,218	48,429	144,655
STAR+PLUS 217-Like HCBS	17,738	17,787	17,730	53,254

X. CONSUMER ISSUES

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

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

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

A. HOTLINE CALL VOLUME AND PERFORMANCE

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

Attachments M1 through M4 detail the total calls received as well as performance standards for all MCOs and DMOs. Calls to the MCO member hotlines increased by 5.11% in 2016 SFQ4. Calls to the MCO provider hotlines increased by 33.54% and calls to the behavioral health hotline decreased by -5.20% in SFQ4. In the Dental Program, calls to the member hotlines increased by 10.90% in SFQ4 and calls to the provider hotline increased by 5.63%.

The following table shows the number of hotline calls received per 1,000 members in the last four quarters. The rate of member hotline calls received per 1,000 members increased in 2016 SFQ4 across most plans.

Member Hotline Calls Received per 1,000 Members (2016 SFQ1 - 2016 SFQ4)

MCO	Member Hotline per 1,000 Members SFY16			
	Q1	Q2	Q3	Q4
Aetna*	479	483	529	520
Amerigroup*	182	184	192	254
BCBS*	283	300	280	242
CHC*	198	184	182	176
Christus*	881	651	567	572
Cigna-HealthSpring	815	558	535	710
Community 1st*	221	238	231	234
Cook Children's*	224	120	128	211
Dentaquest	72	71	77	87
Driscoll*	155	174	175	158
El Paso 1st*	163	187	128	164
FirstCare*	177	125	144	129
MCNA	111	105	105	113
Molina*	415	578	488	885
Parkland*	251	244	250	247
Scott & White	355	319	308	312
Sendero*	231	428	365	294
Seton*	616	627	455	505
Superior*	197	204	209	252
Texas Children's*	115	134	83	137
United*	407	376	381	804
Statewide (excludes dental program)	**234**	**237**	**230**	**282**

*Enrollment and Hotline data includes CHIP program

Majority of the MCOs and DMOs met the following hotline performance in 2016 SFQ4:

- 99% of all calls must be answered by the fourth ring;
- ≤ 1% busy signal rate for all calls (* for behavioral health no incoming calls receive a busy signal);
- 80% of all calls must be answered by a live person within 30 seconds (* N/A for provider hotlines);
- ≤ 7% call abandonment rate; and
- ≤ 2 minute average hold time.

The following MCOs failed to meet the standards listed above.

Member Hotline, Attachment M1

- 93.65% of Texas Children's member hotline calls were answered by the 4th ring.
- 56.07% (Scott & White) and 40.43% (Seton's) member hotline calls were answered by a live person within 30 seconds.
- Similarly, 23.52% of Scott & White and 32.65% Seton exceeded the ≤7% abandoned calls standard.
- Additionally, First Care, Scott & White, Seton, and Texas Children's exceeded the two minute average hold time.

Behavior Health Hotline (BH), Attachment M2

- 85% of Sendero's calls were answered by the 4th ring.
- 11.08% of First Care's calls exceeded the < 7% abandoned calls standard.

Provider Hotline, Attachment M3

- 21.30% (Scott & White) and 12.51% (United) calls exceeded the ≤7% abandoned calls standard. HHSC recommended liquidated damages due to non-compliance.
- First Care and Scott & White exceeded the two minute average hold time.

HHSC staff reached out to MCOs to inquire reason for non-compliance and have documented appropriate remedies for all MCOs in the respective remedy logs.

Member Hotlines

- Texas Children's reported the reason for non-compliance related to member hotlines answered by the fourth ring were related to a recent move to a new location and issues related to the move. The MCO has taken appropriate steps to avoid future occurrences. Prior to 2016 SFQ4, the MCO had not experienced member hotline issues since 2015 SFQ2.

- HHSC is considering contractual remedies for Scott & White due to non-compliance for calls answered by a live person within 30 seconds, and call abandonment. The MCO reported they are actively working with their vendor to address identified deficiencies. Additionally, the vendor/subcontractor was placed under a Corrective Action Plan (CAP) with the MCO. The MCO continues to obtain weekly updates from the vendor to ensure they are working towards resolution.

- HHSC is considering contractual remedies for First Care due to exceeding the standard for the average hold time. The MCO reported the longer than average hold times were attributed

to attrition. However, the MCO was able to onboard and train new staff to reduce the call abandonment rates.

Behavioral Health Hotlines

- HHSC recommended liquidated damages for Sendero for submitting an inaccurate report.

- Seton was placed under a CAP due to experiencing higher than normal call volume and call duration after the MCO's vendor launched an updated provider portal. As a result, the CAP was put in place in an effort to resolve the abandonment rates and hold times, identify peak call volume times, and ensure appropriate phone coverage. HSHC monitors progress the aforementioned issues on a monthly basis.

- HHSC is considering contractual remedies for Scott & White due to failure to meet the call hold and call abandonment rates.

Provider Hotlines

- Scott & White reported deficiencies due to subcontractor's reporting stemming from 2016 SFQ3. HHSC recommended liquidated damages for failure to meet contractual standards for call abandonment and average hold time rates. HHSC reported that this is the first occurrence for this MCO since there is no history of a similar violation within the past 24 months.

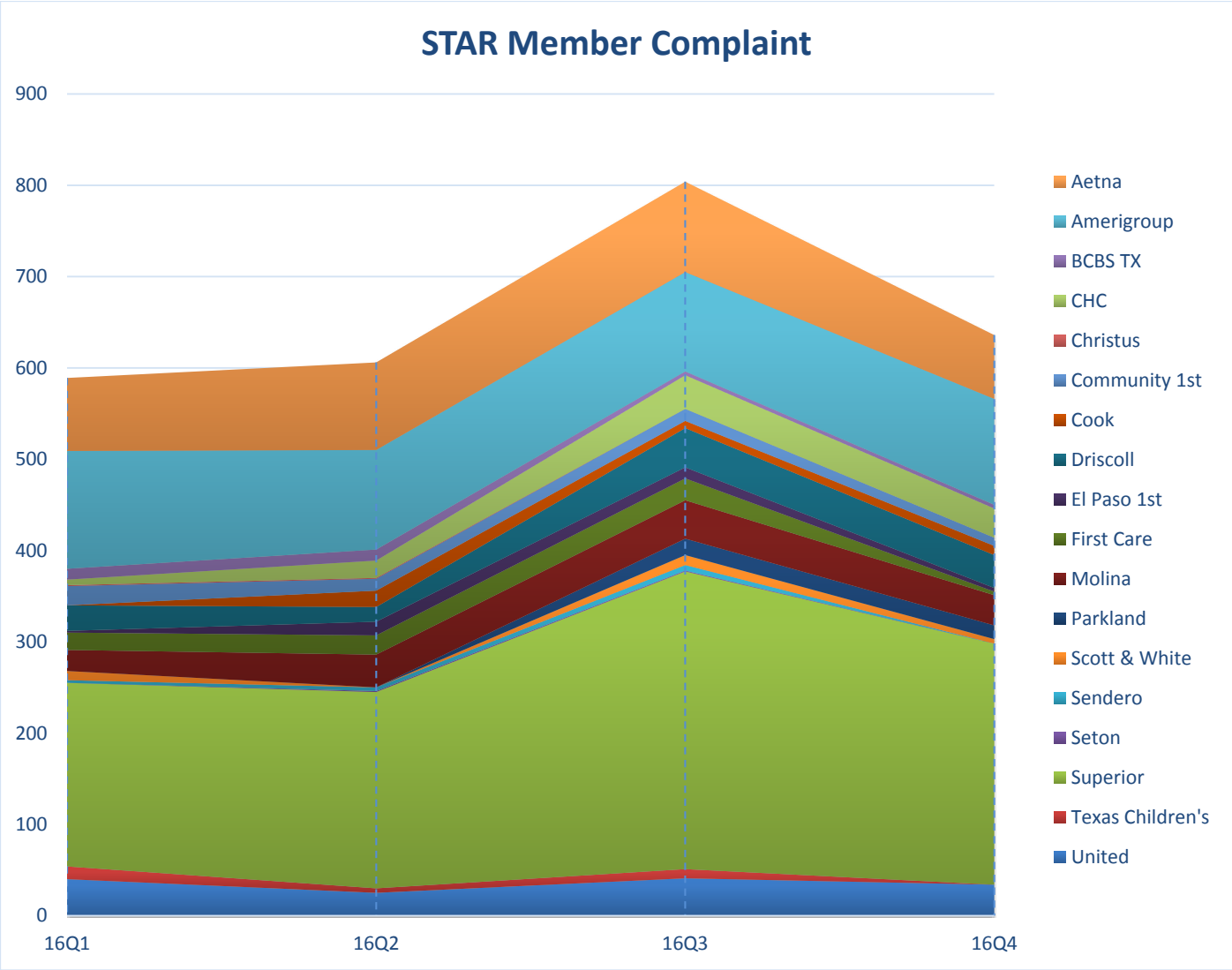
B. COMPLAINTS AND APPEALS RECEIVED BY PLANS

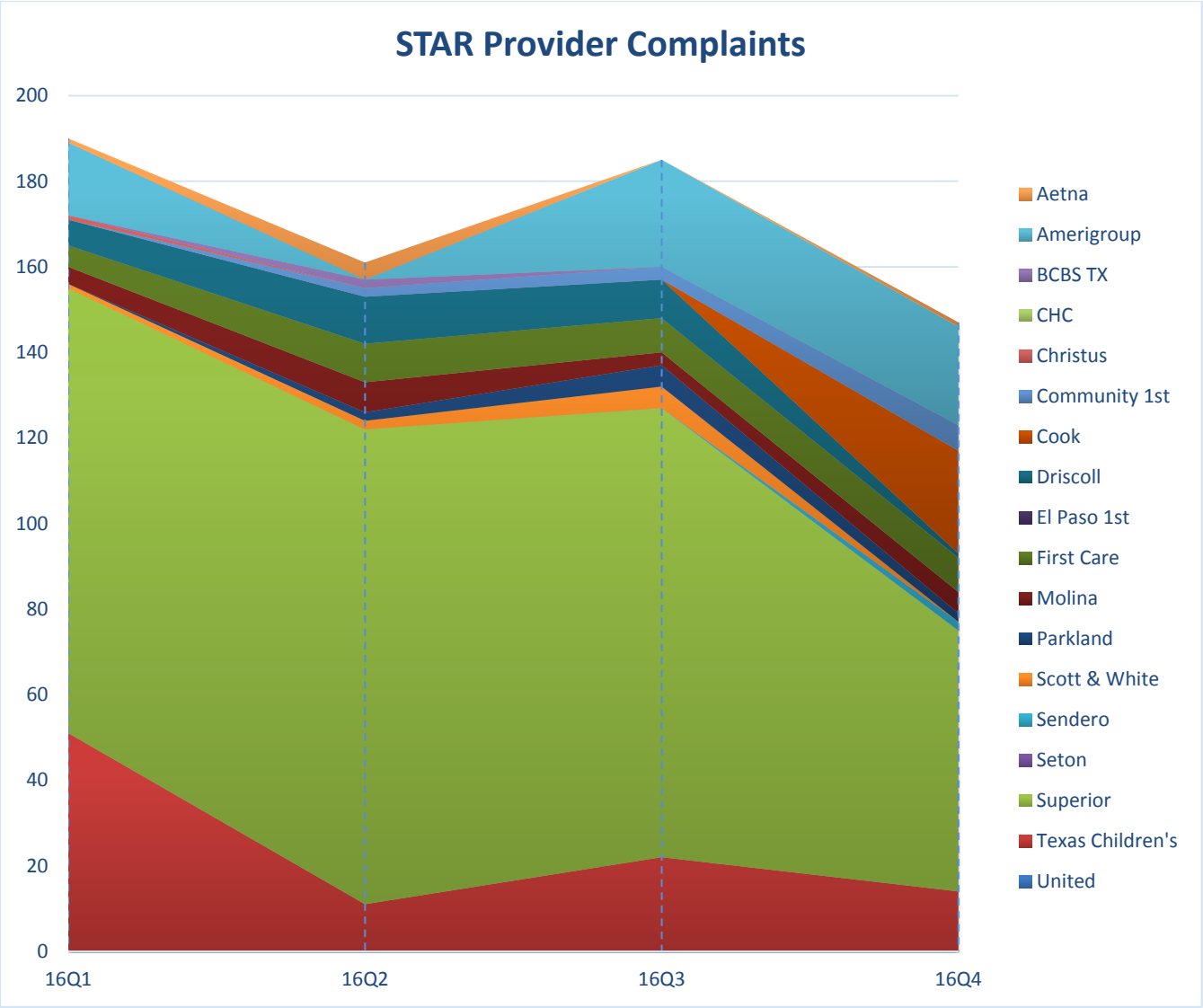
Attachment N shows the number of member complaints and appeals and provider complaints resolved by MCOs and DMOs.

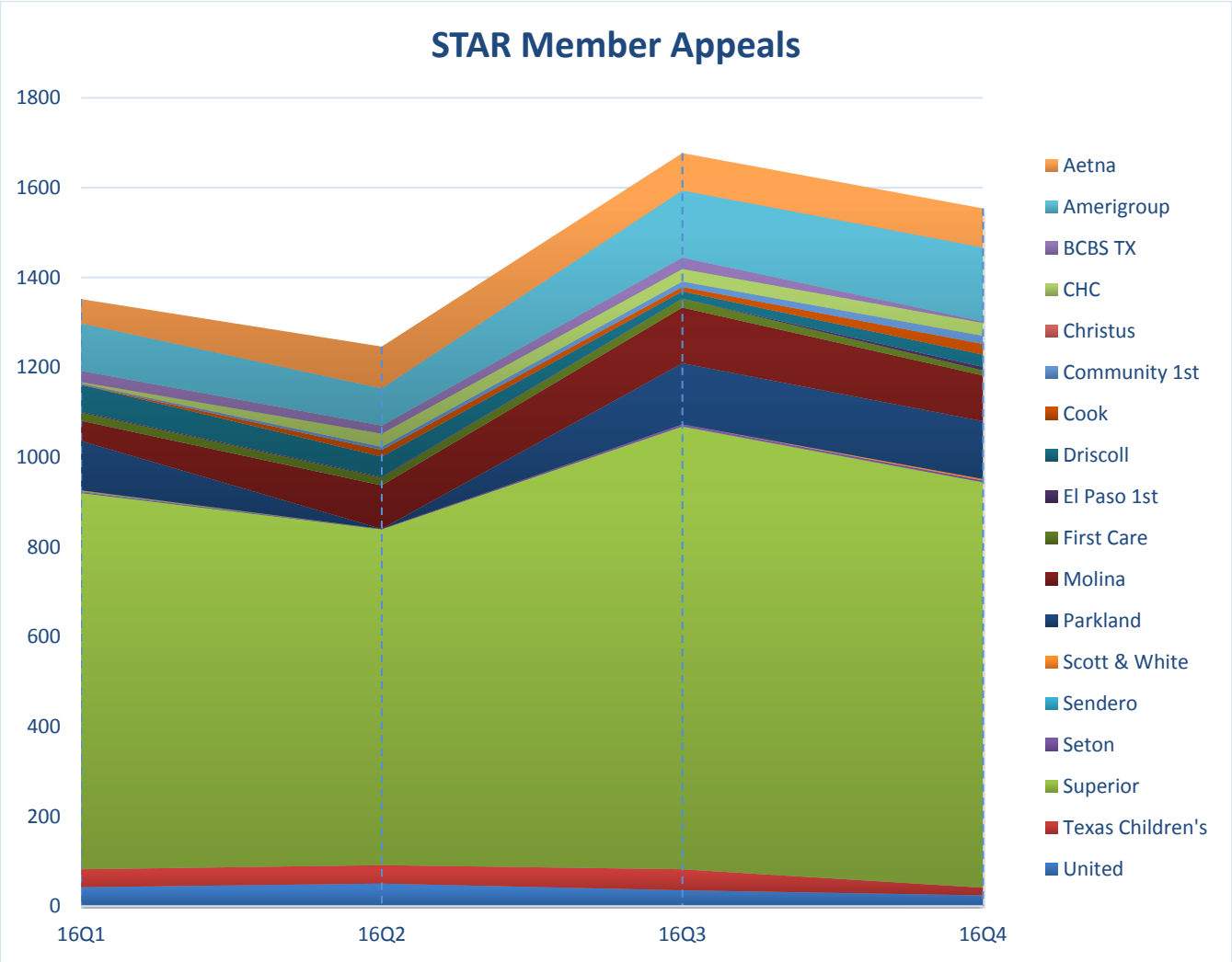
1. STAR and STAR+PLUS

The total number of STAR complaints and appeals received by plans decreased from 2,666 in 2016 SFQ3 to 2,337 in 2016 SFQ4, as shown in the following figures below. The total number of STAR+PLUS complaints and appeals increased from 3,335 in 2016 SFQ3 to 4,528 in 2016 SFQ4. STAR plans collectively reported 636 member complaints, 1,554 member appeals and 147 provider complaints in SFQ4. STAR+PLUS plans reported 1,241 member complaints, 1,762 member appeals and 1,525 provider complaints in SFQ4. The STAR+PLUS MCOs received significantly more member complaints and appeals per 1,000 members than the STAR MCOs due to the complicated medical needs of the STAR+PLUS population.

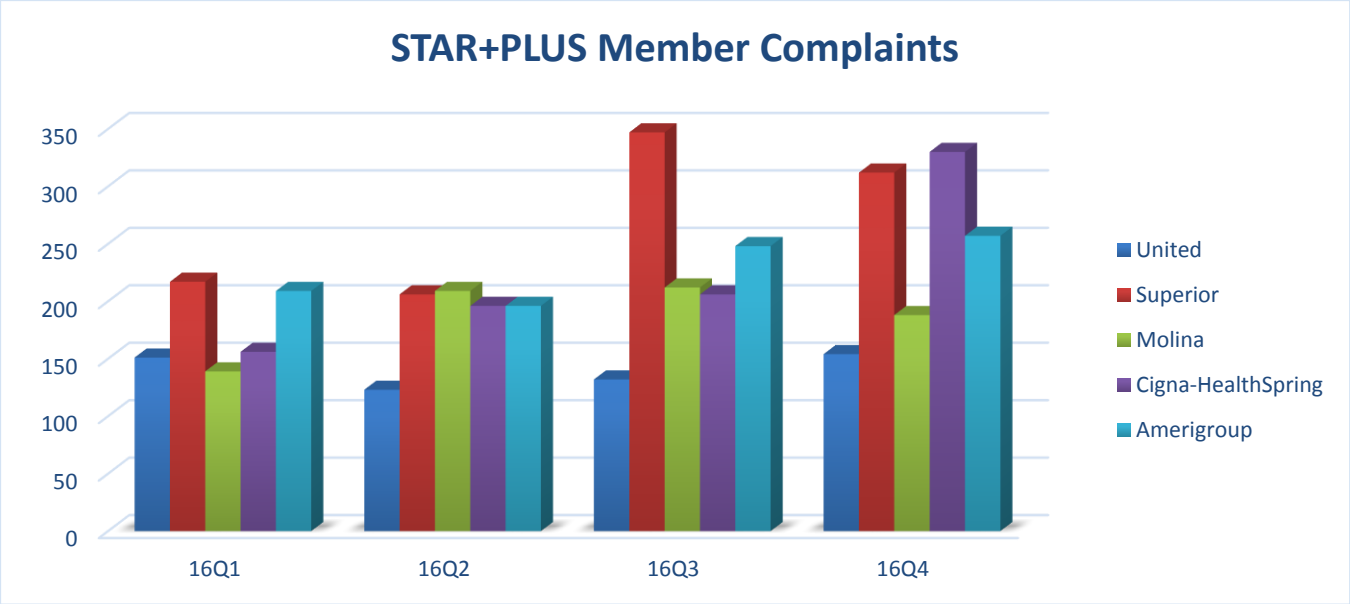
Complaints and Appeals Received by STAR MCOs (2016 SFQ1 – 2016 SFQ4)

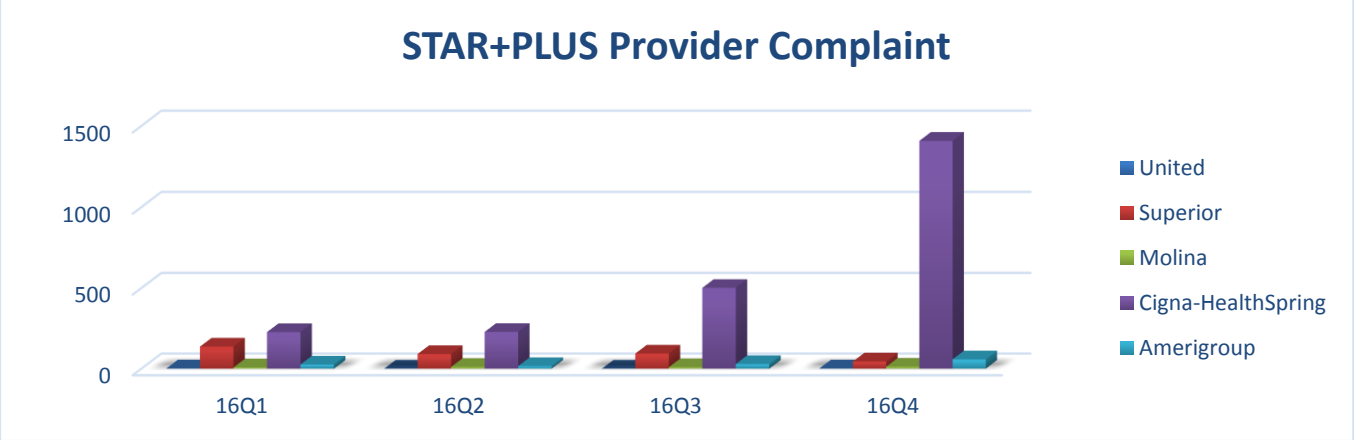

STAR Member Complaint
900
800
700
600
500
400
300
200
100
0
16Q1
16Q2
16Q3
16Q4
Aetna
Amerigroup
BCBS TX
CHC
Christus
Community 1st
Cook
Driscoll
El Paso 1st
First Care
Molina
Parkland
Scott & White
Sendero
Seton
Superior
Texas Children's
United

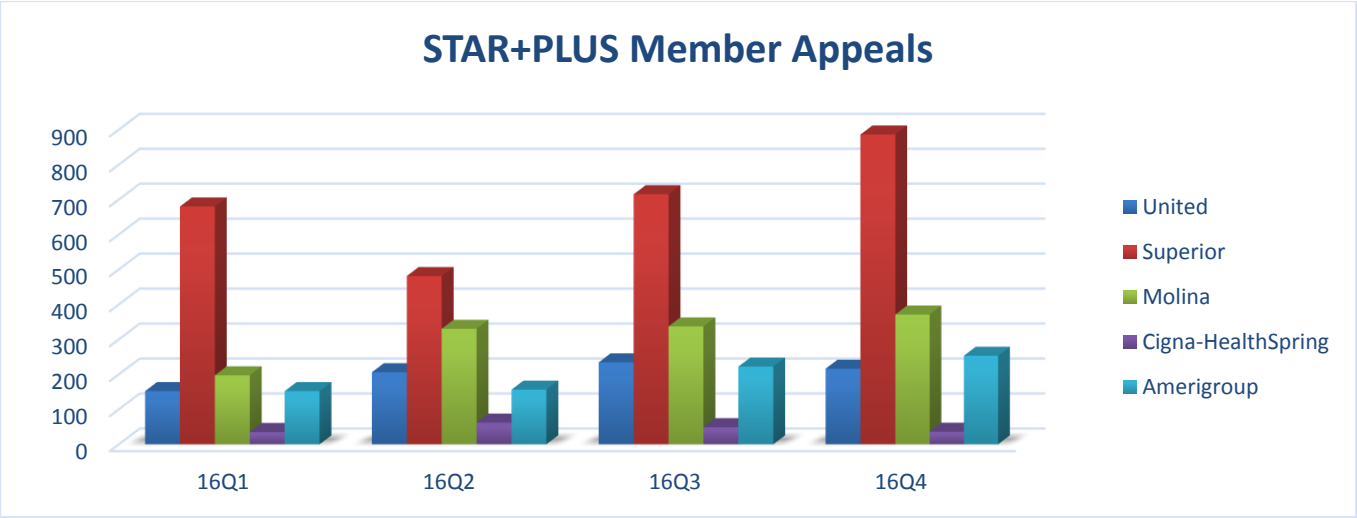

STAR Provider Complaints
200
180
160
140
120
100
80
60
40
20
0
16Q1
16Q2
16Q3
16Q4
Aetna
Amerigroup
BCBS TX
CHC
Christus
Community 1st
Cook
Driscoll
El Paso 1st
First Care
Molina
Parkland
Scott & White
Sendero
Seton
Superior
Texas Children's
United


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

Complaints and Appeals Received by STAR+PLUS MCOs (2016 SFQ1 – 2016 SFQ4)







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

Dental

- DentaQuest failed to meet the timely resolution standard for member complaints in 2016 SFQ4 due to an internal routing error. DentaQuest achieved a 96.67% compliance rating for 2 out of 60 complaints being resolved over 30.days. HHSC recommended liquidated damages for DentaQuest due to non-compliance with member complaints.

STAR

- Most STAR MCOs achieved compliance with the timely resolution of member complaints with the exception of Parkland Dallas SDA who failed to meet timely resolution of member complaints within 30 days.
- Aetna Bexar SDA and First Care Lubbock SDA failed to meet the timely resolution benchmark for member appeals within 30 days in 2016 SFQ4.
- Most of the STAR MCOs achieved compliance with provider complaints resolved 100% within 30 days with the exception of Superior El Paso SDA who did not meet the standard of provider complaints resolved within 30 days.

STAR+PLUS

- Two MCOs failed to meet the timely resolution standard for member complaints in the following SDAs:
    - Superior: MRSA Central and Nueces SDAs

- Molina El Paso SDA Hidalgo and Lubbock.

- Only two MCOs failed to meet the timely resolution standard for member appeals:
  - Cigna-Health Spring: MRSA Northeast SDA and
  - United in the Harris SDA
- Only Two MCOs failed to meet the timely resolution standard for provider complaints:
  - Superior: Bexar and Dallas SDAs.
  - United Harris SDA

HHSC staff are in the process of developing appropriate remedies for the MCOs listed above that did not meet timely resolution standards for complaints and appeals.

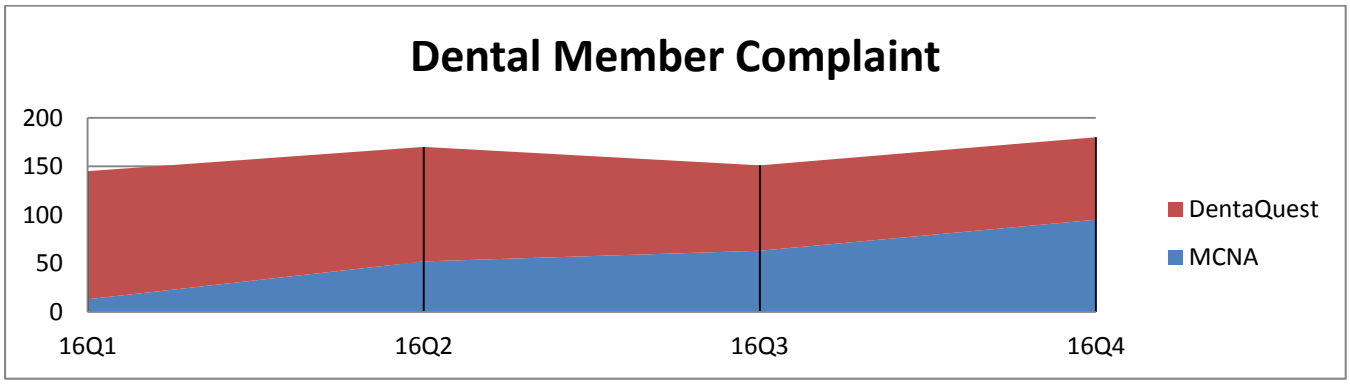
2. Dental Program

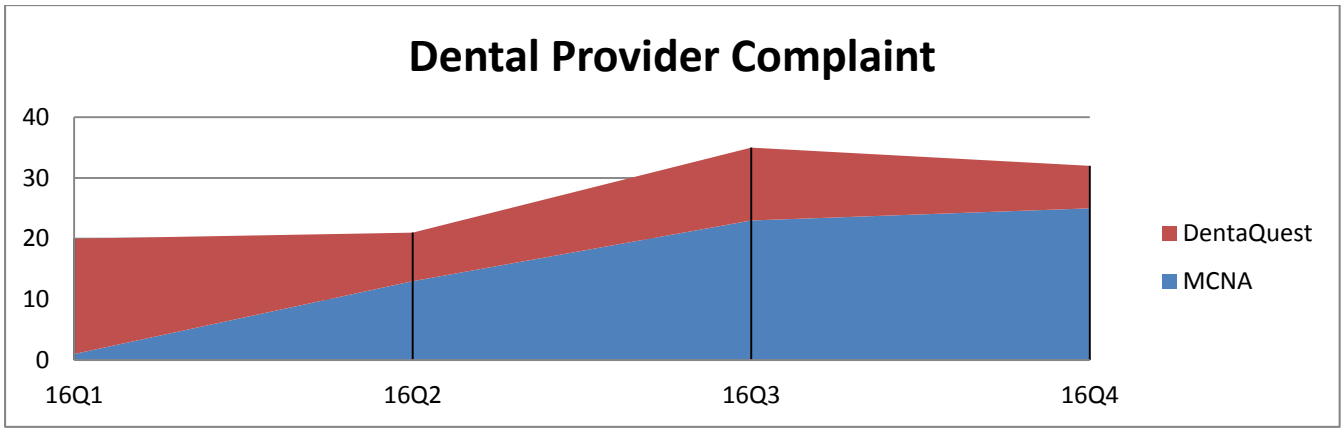
Between 2016 SFQ3 and 2016 SFQ4, dental member complaints increased by 19.2% (from 151 in SFQ3 to 180 in SFQ4), member appeals decreased by 2.34% (from 214 in SFQ3 to 209 in SFQ4) and provider complaints decreased by 8.6% (from 35 in SFQ3 to 32in SFQ4) . The most common member complaint to the dental plans involved either dissatisfaction with the quality of care provided by a treating dental provider or access to or availability of services. Member appeals were primarily related to dental plans utilization review or management such as the denial of prior authorization requests. General complaints by providers were regarding claims processing or plan administration.

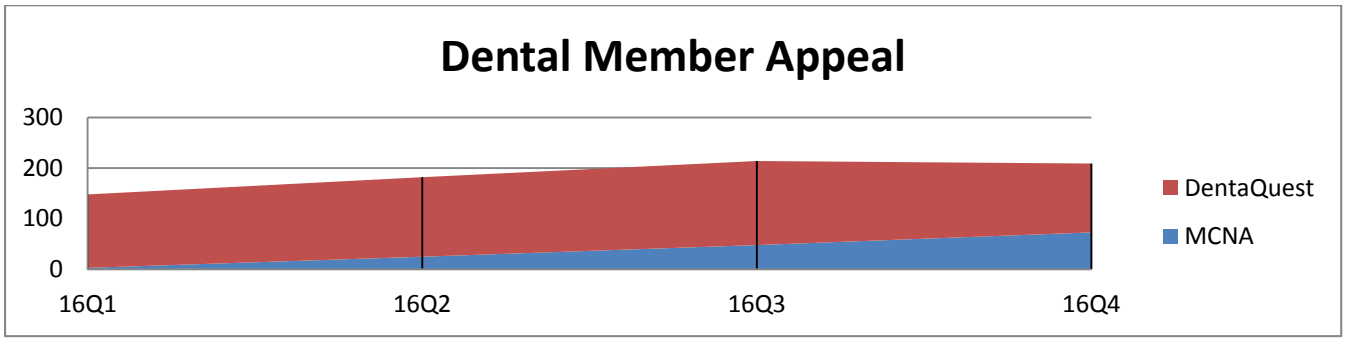
Complaints and appeals are reported in aggregate for each statewide dental plan.

MCNA and DentaQuest met all performance standards for the timely resolution of complaints and appeals in 2016 SFQ4 with the exception of DentaQuest failing to meet timely resolution of member complaints.

Complaints and Appeals Received by DMOs (2016 SFQ1– 2016SFQ4)







C. COMPLAINTS RECEIVED BY THE STATE

Attachment O includes information concerning Dental, STAR and STAR+PLUS complaints received by the State.

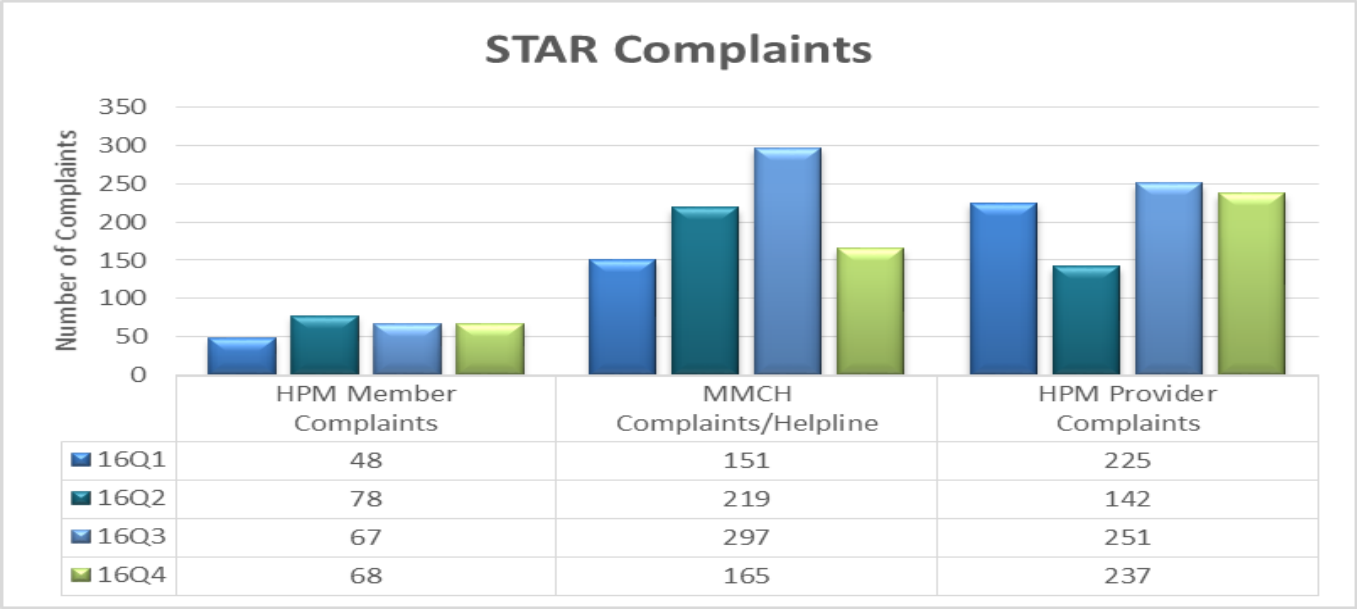
In addition to monitoring complaints received by plans, HHSC also tracks the number and types of complaints submitted to the State. Members and providers can submit complaints to the HHSC Health Plan Management (HPM) team. Members can also call in to submit member and provider complaints through the Office of the Ombudsman via the MMCH. After investigating each complaint, staff determines whether or not it is substantiated. Substantiated complaints are those where there is a clear indication that agency policy was violated or agency expectations were not met (e.g., a member did not receive medically necessary benefits).

1. STAR

In the STAR program, the number of member complaints received by HPM remained relatively constant 1.5% (67 in Q3 and 68 in Q4) and the number of member complaints received by MMCH decreased by 44.4% (from 297 to 165) from 2016 SFQ3 to 2016 SFQ4. HPM received nine contacts on behalf of members from legislative representatives. The most common member complaints received by HPM and MMCH were issues with member claims, access to care,

durable medical equipment, billing and prescription related issues (coverage and copay limits). The number of provider complaints received by HPM decreased by -5.6% (from 251 to 237) in 2016 SFQ4. The most common type of provider complaints received by HPM was denial of claim.

Complaints to the State Regarding STAR (2016 SFQ1 - 2016 SFQ4)

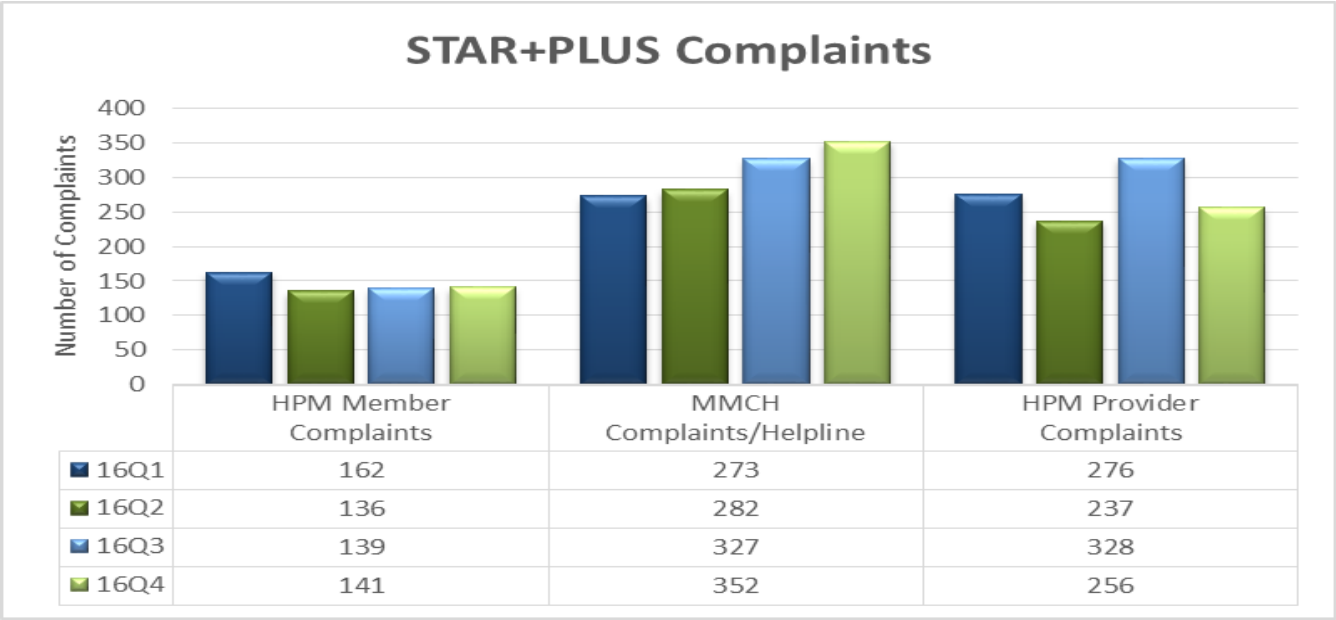


	HPM Member Complaints	MMCH Complaints/Helpline	HPM Provider Complaints
16Q1	48	151	225
16Q2	78	219	142
16Q3	67	297	251
16Q4	68	165	237

2. STAR+PLUS

Across the STAR+PLUS program, the number of member complaints received by MMCH increased by 7.6% (from 327 to 352) in 2016 SFQ3 to SFQ4. The member complaints received by HPM increased by 1.4% (from 139 to 141). HPM received 43 contacts on behalf of members from legislative representatives. The most common issues of member complaints received by MMCH and HPM were issues with benefits, durable medical equipment (DME), enrollment utilization reviews, access to care and prescription related issues (coverage and copayments). The number of provider complaints decreased by -22% (from 328 to 256) in 2016 SFQ3 to SFQ4.

Complaints to the State Regarding STAR+PLUS (2016 SFQ1 - 2016 SFQ4)

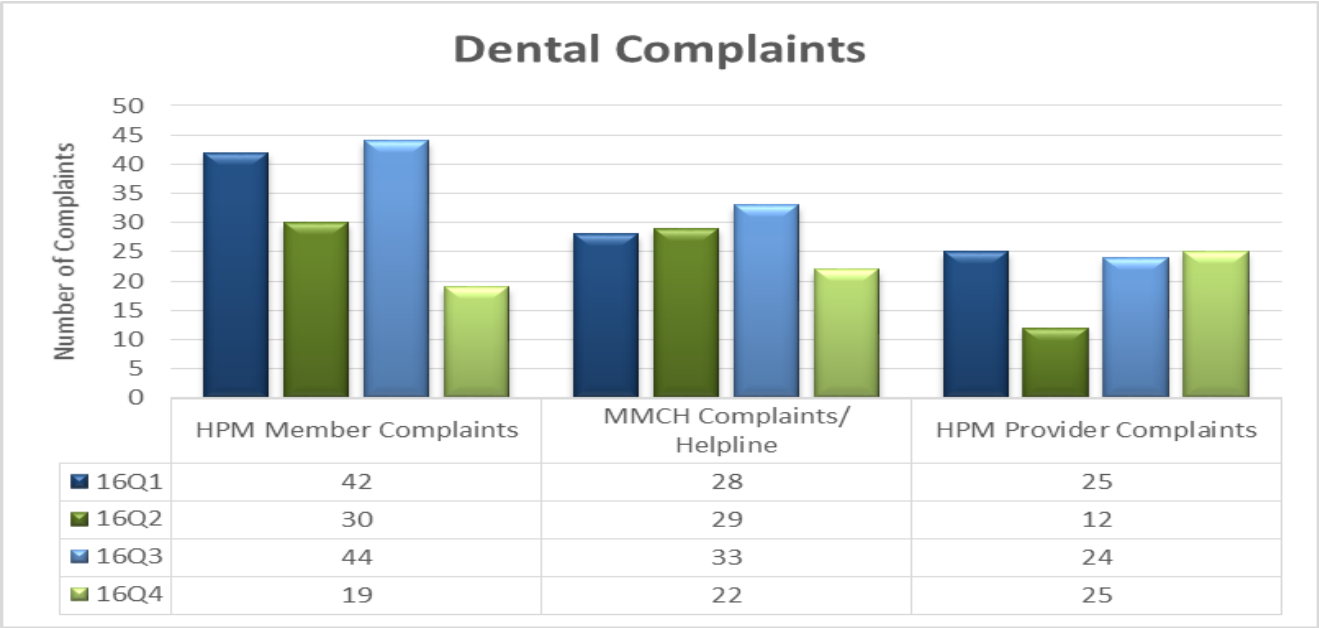


	HPM Member Complaints	MMCH Complaints/Helpline	HPM Provider Complaints
16Q1	162	273	276
16Q2	136	282	237
16Q3	139	327	328
16Q4	141	352	256

3. Dental Program

Across the Dental Program, the number of member complaints received by MMCH decreased by -33.3% (from 33 to 22) in 2016 SFQ4. The number of member complaints received by HPM decreased -56.8% (from 44 to 19) in 2016 SFQ4. The most common member complaint issues received were regarding incorrect eligibility or enrollment information. The most common provider complaint issue received was denied claims. Provider complaints increased by 4.2% (from 24 to 25) in 2016 SFQ3 to SFQ4.

Complaints to the State Regarding the Dental Program (2016 SFQ1 - 2016 SFQ4)



	HPM Member Complaints	MMCH Complaints/ Helpline	HPM Provider Complaints
16Q1	42	28	25
16Q2	30	29	12
16Q3	44	33	24
16Q4	19	22	25

XI. QUALITY ASSURANCE/MONITORING ACTIVITY

This section covers quality assurance and monitoring activities that occurred in DY5 SFQ4.

A. DY5 QUARTER 4 UPDATE

On June 14th HHSC and Texas's EQRO held a Performance Improvement Project (PIP) workshop for the health plans. The agenda included:

- Discussion of barriers, strengths and opportunities for collaborative PIPs;
- Panel of Delivery System Reform Incentive Payment (DSRIP) providers and health plans that are collaborating together on PIPs;
- Presentation of 2017 PIP topics which were developed using a stakeholder workgroup; and
- Technical assistance to the health plans on their 2016 and 2017 PIPs.

On July 1st the health plans submitted annual progress reports on all of their PIPs.

During July and August, Texas's EQRO conducted administrative interviews via teleconference with 18 of the State's health plans. The teleconferences focused on care coordination, including

types of programs, how programs are implemented, what resources are used to help facilitate care coordination and care transitions, how the health plans define success of their programs, the strengths and challenges encountered, how care coordination improves the quality of life for members, and the role of health information technology.

B. ANNUAL UPDATE

Report Cards

HHSC released updated MCO report cards to help members of STAR and STAR+PLUS identify and select an MCO. Similar to prior year report cards, a separate report card was developed for each service delivery area to provide information on the performance of each MCO with respect to outcome and process measures. Results allow members to easily compare MCOs on quality domains of interest to them. The 2015 report cards were made available to members on the HHSC website and included in the enrollment packets sent to all newly eligible members beginning in February. The measures will continue to be reviewed and updated annually.

Quality Forum

On November 5, 2015, HHSC hosted the Fall Medicaid/CHIP Managed Care Quality Forum. The event included presentations related to super-utilizers in Medicaid, improving the identification of quality and value in newborn care, and breakout sessions to discuss the feasibility of a state-wide Performance Improvement Project (PIP) related to super utilizers.

Performance Improvement Projects

MCOs submitted their 2016 PIP plans in September 2015. HHSC requires each health plan to conduct two two-year PIPs per program and one must be in collaboration with another Medicaid/ CHIP managed care organization, dental maintenance organization, or DSRIP project. For the 2016 PIPs, topics were assigned to plans individually and related to reducing the top reasons for potentially preventable events. Dental plans have been tasked with increasing the utilization of preventative services. Ten health plans collaborated with DSRIP providers on interventions such as data sharing, expanding patient access to primary care, patient education, community outreach, and care coordination.

On November 6, 2015, Texas's (EQRO), the Institute for Child Health Policy (ICHP), and the HHSC Medicaid/CHIP Services Department held a collaborative PIP workshop for health plans, Regional Healthcare Partnership (RHP) anchors, and collaborating DSRIP providers. Workshop attendees discussed with their partners, HHSC, and ICHP staff how to address barriers and brainstormed best practices.

In March and April 2016, HHSC pulled together a workgroup of internal and external stakeholders to assist in selecting 2017 Performance Improvement Project (PIP) topics with ICHP participating as a resource. Five MCOs were selected for participation based on their performance on quality improvement deliverables, their network size, programs, and service area coverage, variety of disease management programs, and prior history of robust PIP interventions at the member, provider, and systems level. The purpose of the workgroup was to:

- obtain Managed Care Organization (MCO) and HHSC input;
- ensure the selected topics are feasible and address issues pertinent to the State and the MCOs;
- better coordinate initiatives;
- enhance engagement/investment in the PIPs; and
- ensure topics are conducive to collaboration (in particular, collaboration with DSRIP projects and providers).

HHSC used the workgroup's suggestions and feedback to create a list of options the plans could choose from based on the areas of needed improvement for each plan. The 2017 PIP topic options (depending on the program and individual plan performance) were breast and cervical cancer screening, diabetes control, behavioral health, asthma, and well-child visits in the first 15 months of life. For the STAR Kids, STAR Health, and dental programs, health plans were allowed to propose a topic for approval by HHSC.

On June 14, 2016, HHSC and ICHP held a PIP workshop for the health plans. The agenda included:

- Discussion of barriers, strengths and opportunities for collaborative PIPs;
- Panel of Delivery System Reform Incentive Payment (DSRIP) providers and health plans that are collaborating together on PIPs;
- Presentation of 2017 PIP topics which were developed using a stakeholder workgroup; and
- Technical assistance to the health plans on their 2016 and 2017 PIPs.

On July 1, 2016 the health plans submitted annual progress reports on all of their PIPs.

Administrative Interviews

HHSC received the EQRO's Administrative Interview evaluations and participated in the local site visits held October 6, 2015 through December 4, 2015. The agenda items included:

- identification and dissemination of best practices,
- provider incentives and value based payment, and
- network adequacy.

The EQRO provided HHSC with summaries of the calls and meetings.

During July and August 2016, Texas's EQRO conducted administrative interviews via teleconference with 18 of the State's health plans. The teleconferences focused on care coordination, including types of programs, how programs are implemented, what resources are used to help facilitate care coordination and care transitions, how the health plans define success of their programs, the strengths and challenges encountered, how care coordination improves the quality of life for members, and the role of health information technology.

National Core Indicators for Aging and Disabilities survey

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

Quality Measurement

HHSC received the annual HEDIS and potentially preventable events (PPE) data from the EQRO for measurement year 2014. These results were loaded onto the Texas Healthcare Learning Collaborative portal. Texas's EQRO began providing monthly PPE data to the health plans in September 2015. Throughout the year, HHSC received CAHPS survey results for behavioral health, CHIP, dental, and STAR child.

Appointment Availability Studies

As part of an initiative to examine ways to improve network adequacy in Medicaid managed care, HHSC contracted with its EQRO to conduct a study on appointment availability and wait times for Medicaid primary care, behavioral health, OB/GYN, and vision providers throughout the state. The study consists of data collected by the EQRO through phone calls to providers. The sample of providers was drawn from all MCOs and in all SDAs to determine the availability of appointments with providers in STAR and STAR+PLUS. As part of the study, EQRO staff assumes the role of a health plan member and contacts the provider to attempt to make an appointment. The EQRO then collects data on appointment/provider availability that can be compared against self-reported MCO data.

STAR Kids implementation

As part of the implementation of STAR Kids, appropriate performance measures were selected and developed. Existing quality initiatives and activities were reviewed to determine the impact of the new program and ensure that all federal and state requirements are met.

Quality Assessment and Performance Improvement Programs

The health plans submitted their Quality Assessment and Performance Improvement (QAPI) program summary for calendar year 2015 to Texas's EQRO. The EQRO evaluated the QAPI reports and HHSC reviewed these reports and shared them with the health plans.

XII. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 70, regarding evaluation activities and issues.

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from July 1, 2016 through September 30, 2016.

The Program includes two interventions:

> **Intervention I**: The expansion of the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide; creating a new children's dental program, while carving-in prescription drug benefits; nursing facility services; and, the behavioral health services of targeted case management and rehabilitative services (Evaluation Goals 1-4).
>
> **Intervention II**: The establishment of two funding pools that will assist providers with uncompensated care costs and promote health system transformation (Evaluation Goals 5-11).

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

This report identifies:

- The current quarter's evaluation activities,
- Any challenges or issues encountered, and
- Planned evaluation activities in the next quarter.

B. SUMMARY OF EVALUATION ACTIVITIES

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

1. HHSC's Office of Center for Analytics and Decision Support's evaluation team ("HHSC CADS") and the Texas A&M School of Public Health, including its subcontractors the University of Louisville School of Public Health and Information Sciences and The University of Texas School of Public Health (collectively referred to as "Texas A&M"), attended monthly meetings and continued discussions regarding evaluation activities, including data collection, data requests, analysis, and preliminary results.
2. During the 15-month extension of Texas' 1115(a) waiver, HHSC CADS will continue to work with CMS and HHSC program staff to develop new STC evaluation questions for

waiver negotiations. The extension has no impact on the draft Final Evaluation Report due January 31, 2017 (STC 73(b)).
3. HHSC CADS and the University of Texas School of Public Health have successfully submitted an Institutional Review Board (IRB) application to the Texas Department of State Health Services (DSHS) to link patient identifiers from two large intervention sites and two large comparison sites for the purpose of obtaining Medicaid utilization rates from HHSC and hospital discharge data from DSHS for additional analyses of patient-level data.

HHSC Evaluation Activities: Interventions I & II

General Evaluation Activities

1. HHSC CADS evaluation staff attended project meetings and scheduled monthly CMS calls.
2. HHSC CADS evaluation staff attended a CMS all-state SOTA call requesting members on September 8, 2016.
3. HHSC CADS attended Regional Healthcare Partnership (RHP) anchor calls.
4. HHSC Research Specialists, Angie Cummings, DrPH, and Erin Gardner, MPH, joined the HHSC Evaluation Team on September 1, 2016.

Angie Cummings, DrPH, Evaluator

Angie Cummings is a Research Specialist with Texas Health and Human Services Commission, Center for Analytics and Decision Support (CADS). She spent the last year working as the Health Equity Evaluator in the Center for Elimination of Disproportionality and 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. Her areas of interest include community health, health equity, health disparities, maternal and child health, global health, and public health program planning and evaluation. She is an Adjunct Assistant Professor in the Division of Management, Policy, and Community Health at The University of Texas School of Public Health. 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.

Erin Gardner, MPH, Evaluator

Erin Gardner serves as a member of the Evaluation Team in the Center for Analytics and Decision Support of the Texas Health and Human Services Commission. Her previous experience includes evaluation of state and federal immunization programs for the Immunization Unit of the Texas Department of State Health Services. Erin received her Master of Public Health degree in Epidemiology from the Tulane University School of Public Health and Tropical Medicine and her Bachelor of Arts degree in Biology from The University of Texas at Austin.

Intervention I

1. HHSC CADS and a Texas A&M representative attended the Statewide Learning Collaborative on August 30 - 31, 2016 in Austin, Texas.
2. HHSC CADS is drafting a description to Medicaid/CHIP staff on how the evaluation design will be modified with the inclusion of amendment 14: Adoption Assistance, Permanency Care Assistance, and Medicaid Breast and Cervical Cancer Amendment.
3. HHSC CADS is finalizing the sections on Evaluation Goals 1-4 for final report to Program demonstration years (DYs) 2014-2015.
    a. Fee-for-service claims and Managed Care encounters
    b. Eligibility files

Intervention II

1. HHSC CADS members met on a monthly basis with Texas A&M team members to review progress on evaluation activities.

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

1. HHSC CADS continued to monitor progress in this project, which focused during the last quarter on procuring patient level data from participating community mental health centers.

Texas A&M Evaluation Activities: Intervention II

Evaluation Goal (EG) 5

1. The team met on a monthly basis with HHSC CAD to discuss evaluation activities.
2. Conducted all descriptive and statistical analysis for describing the pattern of UC in Texas.
3. Summarized the full DSRIP payments during the wavier and how it relates to the UC pool payments.
4. Compared results with those reported on the UC Health Care Management Associates (HMA) report.
5. Drafted the final report with the results for executive summary and detailed analysis to HHSC.

Evaluation Goals (EG) 6-8

1. The team met on a monthly basis with HHSC CAD to discuss evaluation activities.
2. The team completed analyses of site level attributes for both project and comparison sites.
3. A manuscript was accepted for publication: Pennel, C., Tamayo, L., Wells, R., Sunbury, T. (2016). Emergency medical service-based care coordination for three rural communities. *Journal of Health Care for the Poor and Underserved*. 27:159–180.
4. Truven and Texas Health Care Information Collection (THCIC) data were obtained to generate an average estimated emergency department (ED) charge for the patients who

participated in the winter 2016 phone survey. This estimate was intended to illustrate cost implications of any differences in patient-reported ED use.
5. The team submitted a draft final evaluation report to HHSC CAD on September 1, 2016.
6. The team worked with two large DSRIP Care Navigation (CN) sites and two large comparison site to obtain patient data for either patients who had received DSRIP-funded ED care navigation services (at the sites with those programs) or for patients who were frequent ED users (≥ 5 times/year) at comparison sites. These data will be used for additional analyses of patient-level hospitalization data.

Evaluation Goal (EG) 9

1. The team met on a monthly basis with HHSC CAD to discuss evaluation activities.
2. Texas A&M completed the second wave of data collection.
3. Texas A&M completed qualitative analysis of Time (T) 0, T1, and T2 survey questions.
4. Texas A&M submitted the first draft of the final report on EG9 to HHSC for review and comment. Revisions are ongoing.
5. Texas A&M submitted revisions for the manuscript on EG 9 findings submitted for publication in *Public Administration Review*.

Evaluation Goal (EG) 10-11

1. The team met on a monthly basis with HHSC CAD to discuss evaluation activities.
2. Texas A&M completed comparative analyses on EG 10-11 for the final report.
3. Texas A&M completed learning collaborative analyses for inclusion in the final report.
4. Texas A&M submitted the first draft of the final report on EG9 to HHSC for review and comment. Revisions are ongoing.

Texas A&M Evaluation Activities: Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)

1. The research team obtained approval from DSHS IRB to obtain hospital discharge data, using patient identifiers provided by participating community mental health centers for all patients who have received integrated primary/behavioral care in site projects.
2. Construction of patient measures and analyses were further refined. Dr. Kite continued working with a pilot site to pull and format patient-level data for analyses of patient outcomes before and after receiving integrated primary/behavioral health care. Using the lessons learned from working with the pilot site, Dr. Kite worked with the other nine sites to obtain patient-level data; the team had received data from six of those sites by the end of this reporting period, and anticipate receiving data from the remaining sites in October.
3. Dr. Kite continued cleaning data received from community centers, in preparation for requesting Medicaid data from HHSC and hospital discharge data from DSHS on November 1.
4. Descriptive profiles of the integrated projects were shared as a poster at the 23rd NIMH Conference on Mental Health Services Research (August 1 – 3, 2016, Bethesda, MD).

The team also began drafting a manuscript describing these projects, for submission to a journal.

Challenges or Issues Encountered

Obtaining data for the ***Integrating Primary Care into Behavioral Health Settings for Adults with Severe and Persistent Mental Illnesses (SPMI)*** proved to be more challenging than expected, because this is the first time most or all of these organizations have shared these data for research purposes and community mental health centers generally have limited information systems. For instance, some data were not available electronically at all, and are being manually entered from PDF files (in a fully HIPAA-compliant manner). The evaluation team has continued working closely with all participating centers, with active support from their state membership association, the Texas Council of Community Centers.

C. ACTIVITIES PLANNED IN NEXT QUARTER

(October 1, 2016 through December 31, 2016)

1. HHSC CADS will attend project meetings and monthly CMS calls, as well as RHP anchor calls.
2. HHSC CADS and Texas A&M will continue to meet monthly to collaborate and provide feedback on each other's evaluations.
3. HHSC CADS and Texas A&M will iterate the final evaluation report and begin HHSC review by October 2016.

Intervention I

1. HHSC CADS will finalize the draft of Intervention I evaluation sections for the final evaluation report, which includes longitudinal methodology to examine the impact of Medicaid Managed care expansion.
2. HHSC CADS will coordinate with HHSC internal reviewers and summarize any feedback for Texas A&M and subcontractors.

Intervention II

1. The research teams will respond to two iterations of responses to the draft final report, the first from the evaluation team at HHSC and the second from a wider group. Based on input from a range of HHSC stakeholders within and beyond CADS, the research teams will submit a final report to HHSC.
2. The EG 6-8 team will prepare rosters of patients at ED care navigation and comparison sites for submission to HHSC so that HHSC may procure discharge data and possibly Medicaid claims data. When HHSC has procured the data, the team will begin preparing the data for supplementary hospital use analyses.

3. The EG 9-11 team will begin preparation of RHP-specific reports on findings from EG9 and EGs 10-11.
4. Manuscript preparation will continue.

Integrating Primary Care into Behavioral Health Settings for Adults with SPMI

1. The research team will secure patient-level data from the remaining community mental health centers and will send HHSC rosters of patients for procuring discharge data and possibly Medicaid claims data.
2. HHSC will use patient identifiers provided by the team to request discharge data from the Texas Department of State Health Services. When HHSC returns the pulled data to the team, they will use that to measure patients' hospital use and, potentially, outpatient (Medicaid-billed) use before and after beginning integrated care.
3. Additional analyses may be done with additional patient data provided directly by community mental health centers.

XIII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

This section addresses the quarterly and annual reporting requirements in STC 70 and 71.

A. ACCOMPLISHMENTS

1. Major DSRIP Activities during Federal Fiscal Quarter 1/2016 (10/01/2015-12/31/2015)

Preparing for and processing October DY 4 DSRIP reporting was a large focus of Q1. HHSC staff held a reporting technical assistance webinar for providers covering general reporting, Quantifiable Patient Impact (QPI) reporting and Category 3 guidance. Staff also developed provider-specific reporting templates for QPI and Category 3 reporting. In total for October reporting, providers reported achievement of 56.9 percent of the 9,547 DY3-DY4 Category 1-4 milestones/metrics. HHSC approved 94.3 percent of the reported milestones/metrics for a total of $1,907,016,661 in approved DSRIP payments. Based on available IGT, $1,897,926,133 was paid for DSRIP in January 2016. An additional reporting period for metrics requiring additional information (Needs More Information or NMI) to substantiate achievement opened in December and closed in January 2016. Metrics approved during the NMI reporting period were paid in July 2016, contingent on available IGT.

In Q1, HHSC and the compliance monitor, Myers & Stauffer, LLC, continued to review change request submissions for plan modifications and technical changes for 3-year projects. HHSC provided feedback/final dispositions on change requests in early November.

HHSC continued work on developing proposals for DSRIP program changes and updated protocols for the waiver extension period, in particular the transition year immediately after

Demonstration Year 5, which ends September 30, 2016. HHSC sent CMS in November 2015 a summary of Texas' DSRIP transition year proposal for CMS feedback. Lead time is needed to make operational changes for the transition year, and HHSC noted with the summary that it planned to begin working with DSRIP providers in January 2016 to combine certain similar projects that also meet other criteria determined by HHSC in order to reduce the number of projects while staying within overall project valuation limits. HHSC also noted that in the transition year it planned to lay the groundwork to better demonstrate DSRIP outcomes in the extension period, including for state priority areas.

As part of the DSRIP transition process, HHSC continued reviewing identified projects for possible changes for waiver renewal, including whether they should be continued during the next waiver period. During Q1, HHSC staff reviewed 201 projects, and determined that 131 may continue without modifications in the transition year, 64 may continue with modifications to improve the project, 5 will be discontinued, and one was pending additional information. HHSC notified providers of these determinations in January 2016 (Q2). Most of the discontinued projects are relatively small projects that were not able to get off of the ground. There will be additional projects (including certain types of projects determined to be not as transformative) allowed to continue in the transition year, but for which the provider will need to propose a more transformative project in the later years of the extension, pending CMS approval.

HHSC continued working with Myers & Stauffer, LLC, on ongoing compliance monitoring for reported Category 3 baselines and reported achievement of Category 1 and 2 metrics. The Category 1 - 2 metrics included for the review are select process milestones and QPI. Providers responded to Myers & Stauffer on their Corrective Action Plans. Myers & Stauffer held a webinar for providers to provide an overview of the process for Category 3 baseline reviews and Category 1 and 2 validation of reported metrics.

HHSC also continued working with the Clinical Champions workgroup to review those projects that submitted a Transformational Impact Summary, with many promising practices emerging from this process. To help inform protocols for waiver extension, HHSC and the Clinical Champions worked together to describe effective models for care delivery showing the greatest promise of reaching DSRIP target populations (Medicaid and low-income uninsured), as well as improving clinical, cost and population health outcomes.

In November, Anchors had the opportunity to report costs for anchor administrative reporting by submitting the HHSC-developed Cost Template and Percent-of-Effort spreadsheet with a notarized certification. HHSC staff reviewed Anchor cost submissions and worked with them for additional information as needed. Approved Anchor administrative payments will go out in February 2016.

HHSC developed a template for Anchors to submit their DY4 Anchor Annual reports in December, as required by the Program Funding and Mechanics protocol. Summary information and copies of the reports were included in the HHSC DY4 Annual Report submission.

HHSC continued stakeholder communications in Q1 through webinars, biweekly Anchor calls, and reporting companion documents.

2. Major DSRIP Activities during Federal Fiscal Quarter 2/2016 (01/01/2016-03/31/2016)

In late January and early February of 2016, HHSC staff reviewed provider responses to metrics that were found to need more information to support achievement during October DY 4 DSRIP reporting. Approvals and denials of the additional information submitted were given to providers the last week of February/first week of March. Those metrics that were approved will be eligible for payment in July 2016. For project metrics achieved during the October DY4 reporting period (including DY3 carryforward metrics), DSRIP providers received about $1.9 billion in January 2015. During Q2 HHSC posted the October DY4 payment summary by DSRIP project on the HHSC waiver website, along with the project and provider level summary reports, which provide high-level narrative overviews of the status of all of a provider's projects and project-level status information related to a specific project's accomplishments, challenges, lessons learned, etc.

HHSC completed review of the anchor administrative cost reports submitted during Q1. IGT was requested by January 28th with payments to anchors made February 12, 2016.

During Q2, significant work continued with Category 3. HHSC finalized review of Category 3 baselines submitted during the October DY4 reporting period. HHSC sent providers a summary of reported baselines and goals, in addition to notes about those baselines needing technical assistance. HHSC developed an Interim Category 3 Correction Template that providers were able to submit to make needed corrections to baselines (which included Pay for Performance outcomes that already reported DY4 performance, or those outcomes approved for an alternate achievement level, maintenance, or Pay for Reporting due to small volume) prior to April DY5 reporting. For all other outcomes, HHSC developed a Category 3 project specific reporting summary and goal calculator so that providers can confirm current reporting information and determine new goals if corrections are anticipated.

In Q2, HHSC continued laying the groundwork for the proposed waiver extension period. In January, HHSC began notifying individual providers of the results of the project review HHSC conducted during Q1. This review of projects was undertaken to determine if a project would be eligible to continue or requires changes for the waiver extension period. During project review, HHSC considered reported progress toward goals in addition to completion/incompletion of metrics; reported challenges and delays in implementing projects; transformative value of the

project including whether the project option was removed from the 3-year project menu or draft extension menu; valuation and Medicaid Low-Income Uninsured (MLIU) impact of similar projects across the state; and any similar projects within the region. HHSC determined that almost all of the projects reviewed will be eligible to continue based on the review criteria noted above, but some will require strengthening or next steps, such as increasing Quantitative Patient Impact (QPI) and/or MLIU, requiring MLIU as pay for performance in DY6 and/or taking a logical next step to further transformation in DY6.

Also during Q2 and related to HHSC's waiver extension proposals, HHSC posted a template and companion document for providers to complete if they were interested in combining certain projects into a single project during the waiver extension period (DY6 - 10). The purpose of combining projects is to streamline the DSRIP program to lessen the administrative burden on providers while focusing on collecting the most important types of information. Projects that may combine include cross-regional community mental health center (CMHC) projects; similar projects by the same provider within one region; or similar projects by different providers within the same health system and region. Through this process, the combined valuation of Category 1 or 2 projects may not exceed $5 million in each demonstration year, and combined projects must be from the same project area. Templates were due back to HHSC by early February 2016 and were reviewed by HHSC staff.

During Q2 HHSC also posted on the waiver website draft language for the Program Funding and Mechanics (PFM) Protocol relating to the transition year (DY6). A survey was available for stakeholder feedback on the proposed language. HHSC also posted a draft list of Performance Bonus Pool and Statewide Analysis Plan measures that builds on the information presented at the 2015 Statewide Learning Collaborative, with an ongoing opportunity for stakeholder feedback on these proposed measures. A list of best practice models HHSC identified for project options on the Transformation Extension Menu for replacement projects was posted, with a survey for stakeholder feedback on the Transformation Extension Menu.

In Q2, HHSC continued working with Myers & Stauffer on ongoing compliance monitoring, both review of Category 3 baselines and the beginning of validation of Category 1 & 2 metrics.

During Q2 HHSC staff worked on completing April DY5 reporting templates for QPI and Category 3 as well as an updated reporting companion documents for Category 1&2 and Category 3 reporting containing detailed instructions and examples.

Work with the Clinical Champions workgroup continued in Q2 with a meeting on February 5, 2016. Representatives from some Medicaid Managed Care Organizations (MCOs) were invited to continue the dialogue initiated at the 2015 Statewide Learning Collaborative, including how to establish and facilitate partnerships to further the alignment of DSRIP and MCOs. This will be a continuing area of focus for the Clinical Champions.

HHSC continued stakeholder communications in Q2 through biweekly Anchor calls and an Executive Waiver Committee meeting. On February 5, 2016, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on proposals for the Transition Year (DY6) of the waiver extension.

3. Major DSRIP Activities during Federal Fiscal Quarter 3/2016 (04/01/2016-06/30/2016)

April 2016 was the first opportunity for providers to report achievement of DY5 metrics along with reporting metrics carried forward from DY4. Provider reports were due April 30, and HHSC began reporting review in May and completed it in early June. Providers were sent reporting feedback in June and given until July 6 to respond to requests for additional information to support achievement of 53 metrics.

During the April reporting period DSRIP providers reported achievement of 21.3 percent of the 9,003 DY4-DY5 Category 1-4 milestones and metrics. HHSC approved 97.2 percent of the reported milestones/metrics. Based on available intergovernmental transfer funds (IGT), $4.9 million was collected in Monitoring IGT and $722,433,038 was paid for DSRIP in July 2016. The total DY1 - DY5 DSRIP payments to date is about $7.9 billion. HHSC approved 98 percent of the milestones/metrics that required additional information to substantiate achievement, and those will be included for payment in January 2017.

Anchors were able to report administrative costs during Q3 on May 16, 2016 using the HHSC and CMS approved cost template spreadsheet. HHSC reviewed the administrative cost reports during Q3. Anchor administrative cost payments will be made on August 12 during Q4.

During Q3, Myers & Stauffer continued Component 2 of their monitoring work, which is compliance monitoring for validation of data submitted by performing providers as the basis for their milestone/metric achievement and subsequent DSRIP payments. This validation began with a review of Category 3 baselines and continued with metrics from Category 1 and 2 reporting. Myers & Stauffer reviews Category 1 and 2 metrics in several steps: review of the existing reported information submitted by the provider for a specific metric; review of the additional information requested by Myers & Stauffer; and requesting support for the sample selected by Myers & Stauffer to assess accuracy of the data. All projects that have reported metrics are eligible for review. Once HHSC reviews Myers & Stauffer's findings and recommendations, HHSC may request recoupment of the metric payment for which a provider could not substantiate reporting.

On April 7, 2016, HHSC submitted a request to CMS for an initial 15-month waiver extension to facilitate a transition to the overall requested five-year extension. Texas requested to maintain DY5 funding levels for both Uncompensated Care (UC) and DSRIP, which is $3.1 billion (all funds) for twelve months for each pool, and a prorated amount for the additional three months. Texas would also continue the delivery of Medicaid services through the managed care delivery

model statewide. On May 2, 2016, HHSC received approval of the 15-month waiver extension at the existing funding levels for DSRIP and UC. During the fifteen months, Texas and CMS will continue negotiations on a longer term agreement.

In Q3, HHSC continued work on processes for Demonstration Year 6, which is the initial extension year. Staff worked on two sets of administrative rules for DY6: those that will be effective June 1, 2016 for actions in preparation for DY6 and another set effective September 1 for requirements during DY6. HHSC staff also developed a proposed Program Mechanics and Funding Protocol (PFM) specific to DY6, which sets the guidelines for the 15 month DSRIP program extension, and submitted it to CMS; CMS approved the PFM (Attachment J to the waiver's standard terms and conditions) on June 23, 2016.

Also during Q3 and related to laying the groundwork for DY6, HHSC developed a DY6 DSRIP Participation Template to prepare DSRIP providers for DY6 requirements included in the updated PFM protocol. The template allowed providers to indicate projects that will be continued or discontinued in DY6; view and confirm their DY6 Quantifiable Patient Impact (QPI) and Medicaid and low-income and/or uninsured (MLIU) milestones; request some changes to QPI or MLIU with strong justification; increase total DY6 provider valuation up to $250,000; and update IGT information, among some additional items. Projects that had been under review for continuation by HHSC also used the template to update their required next steps and give project updates. HHSC held a webinar for providers on June 29, 2016 for technical assistance on how to complete the template, which was due to HHSC by July 22, 2016.

HHSC continued stakeholder communications in Q3 through biweekly Anchor calls, Clinical Champions and Executive Waiver Committee meetings. On May 12, 2016, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on the 15-month waiver extension, including the Uncompensated Care study. The Clinical Champions workgroup met May 16th to discuss potential agenda items for the Statewide Learning Collaborative summit. On April 6th, HHSC conducted webinars to provide technical assistance for DY5 reporting (DY5 General Reporting Guidance, Quantifiable Patient Impact, and Category 3 & 4 Reporting Guidance). During Q3 HHSC worked on logistics and the agenda for the annual two-day Statewide Learning Collaborative Summit held in Austin on August 30-31, 2016.

4. Major DSRIP Activities during Federal Fiscal Quarter 4/2016 (7/01/2016 - 9/30/2016)

During Q4, HHSC reviewed the additional reporting information submitted by providers that HHSC had requested in support of achievement of metrics reported in April 2016 and approved 98 percent of these milestones/metrics. Payments for those metrics will be included in the January 2017 payment period. Based on available intergovernmental transfer funds (IGT), $4.9 million was collected in Monitoring IGT and $722,433,038 was paid for DSRIP metrics

achieved in April by July 31, 2016. A total of nearly $7.92 billion in DY1-DY5 metrics have been paid to date.

HHSC continued working with Myers & Stauffer, LLC, on ongoing compliance monitoring on Round 2 Category 1 and 2 and Category 3 Performance review. Myers & Stauffer completed their Category 3 baseline review, and providers were notified of any baseline changes.

For Anchor Administrative Cost claiming, IGT was due by July 22, 2016 and payments to anchors were made August 12, 2016.

During Q4 HHSC continued work on DSRIP program changes and updated protocols for the waiver extension period, in particular for DY6, which is the 15-month (October 1, 2016 - December 31, 2017) extension approved by CMS in May 2016. The DY6 Program Funding and Mechanics (PFM) Protocol was approved by CMS in June. The PFM lays out the revised guidelines by which DSRIP projects will operate in DY6.

DY6 DSRIP Participation Templates were due to HHSC from DSRIP providers by July 22, 2016. These templates prepared DSRIP providers for DY6 requirements included in the updated PFM protocol. HHSC reviewed these templates during August and September in communication with providers, with final approval or denial given by September 30, 2016.

The Special Terms and Conditions for the 15-month waiver extension required Texas to submit a report conducted by an independent evaluator of the state's Uncompensated Care (UC) program that studied the impact of the UC pool on overall UC in the state, Medicaid provider rates, Medicaid beneficiary access to services, and a number of other areas. HHSC contracted with Health Management Associates and Deloitte Consulting to complete the report, which was submitted to CMS as required on August 31, 2016.

On August 19, 2016, HHSC sent a letter to CMS to facilitate discussion on the longer term extension of the waiver. In addition to stating that HHSC was on track to submit the required UC report discussed above, the letter states that HHSC seeks a clear understanding of CMS' vision for DSRIP into Medicaid managed care and discusses HHSC's vision for the longer-term extension. HHSC proposal includes both a glide path for the integration of DSRIP into managed care for Medicaid beneficiaries and the continued support of locally directed interventions for the continued transformation of the health care system for all Texans.

HHSC continued stakeholder communications in Q4 through responses to technical assistance requests, biweekly Anchor calls, and an Executive Waiver Committee meeting. HHSC also held a Statewide Learning Collaborative Summit, discussed more fully below.

5. Major Uncompensated Care (UC) Program Activities During DY5

March 2016

- HHSC issued combined Disproportionate Share Hospital/ Uncompensated Care (DSH/UC) DY5 applications to providers

April 2016

- Completed DY5 DSH/UC applications received from providers
- HHSC processed a 2016 DY5 Advance UC Payment totaling approximately $1,182,276,972.55

May 2016

- HHSC completed the processing of all DY5 DSH/UC applications
- Completed the calculation of hospital specific limits (HSLs) and verification by providers and their consultants

June 2016

- HHSC issued Texas Physician Uncompensated Care (TXPUC) applications to providers

July 2016

- Completed TXPUC applications received from providers
- HHSC completed the processing of all DY5 DSH/UC TXPUCs applications

September 2016

- DY5/FFY16 Final Payment $ 1,582,447,440.84

6. Statewide Learning Collaborative Summit (SLC)

The 2016 DSRIP Statewide Learning Collaborative (SLC) Summit was held in Austin on August 30th and 31st, with over 450 participants in attendance. Participants included DSRIP providers and anchors from all 20 statewide Regional Healthcare Partnerships (RHPs), provider and hospital association representatives, representatives from Managed Care Organizations (MCOs), and health and human service agency staff, among other stakeholders. Representatives from the Centers for Medicare and Medicaid Services (CMS) also participated. In addition to in-person attendance, the SLC was livestreamed over the web, with over 1400 livestream views combined for the two days of the summit.

Special guest speakers included HHSC Executive Commissioner Charles Smith, Teresa DeCaro from the Centers for Medicare and Medicaid Services (CMS), Lisa Kirsch from the Dell Medical School at the University of Texas at Austin, Lindsey Browning from the National Association of Medicaid Directors, Shelli Silver from the Arizona Cost Containment System, and Dr. John Hellerstedt, Commissioner of the Texas Department of State Health Services, along with many DSRIP providers and MCO representatives.

The overall focus of the SLC was to highlight DSRIP project outcomes and impact on the Texas healthcare system during the five years of the waiver so far, and planning for sustainability of projects into future years of the waiver and beyond, including potential integration into Medicaid managed care. Projects from all 20 RHPs were highlighted during the two-day conference. Panelists highlighted DSRIP project achievements and outcomes; presented national, state and local perspectives on Value Based Purchasing and Alternative Payment Models; discussed regional efforts toward sustainability and collaborations; and options for providers to use state data to support quality improvement. Breakout sessions provided peer to peer learning and technical assistance on areas such as data sharing and Health Information Exchanges for both rural and urban providers; successes in innovative projects focusing on care coordination, primary and behavioral health integration, and social determinants of health; practices leading to successful outcome measurement and validation; and how to develop a business case for Value-Based Purchasing and Alternative Payment Models.

Presentations and video recordings of the main panel sessions from the 2016 SLC are posted on the HHSC waiver website here: http://legacy-hhsc.hhsc.state.tx.us/1115-Waiver-Deadlines.shtml

7. Summary of RHP Milestone Achievement in DY5

As required in the Program Funding and Mechanics Protocol, each Anchoring Entity submitted a DY5 Annual Report by December 15, 2016. The reports include a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. A file of all of the DY5 Anchor Annual Reports for all RHPs is included in Attachment W.

HHSC also is providing a high-level summary of performance achievement by each RHP based on the two DY5 reporting periods – April 2016 and October 2016. This data is included in the first tab of Attachment W. 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.

8. Projected DY6 DSRIP Payments

While HHSC's Financial Services staff will provide the official estimates of potential DSRIP payments to CMS for each quarter, based on April and October 2016 reporting, HHSC estimates

that DSRIP providers will earn over $1 billion in DY6 DSRIP funds. This uses the same percentages as in DY5 reporting in which 15 percent of funding was approved in April 2016; an additional 62 percent of funding was approved by October 2016. It does not include DY5 metrics carried forward into DY6 or the Anchor one-time DY6 payments, so the total payment amounts for July 2017 (based on April 2017 reporting) and January 2018 (based on October 2017 reporting) likely will be higher that what is reflected in the following table.

RHP	DSRIP Allocation DY6	Estimated April 2017 Reporting	Estimated October 2017 Reporting
RHP 1	$115,435,131	$17,403,569	$71,472,996
RHP 2	$106,487,390	$16,054,563	$65,932,899
RHP 3	$619,234,661	$93,358,867	$383,406,300
RHP 4	$126,682,676	$19,099,304	$78,437,043
RHP 5	$200,604,147	$30,244,069	$124,206,377
RHP 6	$311,664,402	$46,988,060	$192,970,618
RHP 7	$204,200,435	$30,786,263	$126,433,060
RHP 8	$25,536,311	$3,849,980	$15,811,102
RHP 9	$448,009,036	$67,544,048	$277,389,974
RHP 10	$307,701,304	$46,390,564	$190,516,820
RHP 11	$36,823,614	$5,551,709	$22,799,766
RHP 12	$116,354,929	$17,542,242	$72,042,500
RHP 13	$21,007,292	$3,167,163	$13,006,908

RHP 14	$74,343,030	$11,208,321	$46,030,346
RHP 15	$141,426,699	$21,322,186	$87,565,976
RHP 16	$41,495,521	$6,256,069	$25,692,432
RHP 17	$23,995,689	$3,617,708	$14,857,209
RHP 18	$33,793,894	$5,094,934	$20,923,880
RHP 19	$29,492,473	$4,446,430	$18,260,605
RHP 20	$30,684,828	$4,626,196	$18,998,866
Total	**$3,014,973,462**	**$454,552,245**	**$1,866,755,676**

B. POLICY, ADMINISTRATIVE AND FINANCIAL DIFFICULTIES

The Texas DSRIP program continued to evolve during DY5, as HHSC, CMS, RHP anchors, and DSRIP providers worked to implement the program in a state that is large and diverse. A key challenge was the extension application that was due September 30, 2015 and subsequent negotiations that resulted in the 15-month extension and the protocols for the first 12 months of the extension. The overarching challenge facing HHSC continues to be managing a large, diverse program with aggressive timelines and limited resources, including program policies for the remainder of the current extension and working with CMS on the longer term renewal.

ENCLOSURES/ATTACHMENTS

Attachment A – Managed Care Plans By Service Area. The attachment includes a table of the health and dental plans by Service Delivery Area.

Attachment B -- Enrollment Summary (16Q1-16Q4). The attachment includes annual and quarterly Dental, STAR and STAR+PLUS enrollment summaries.

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

Attachments D1-D2 – Out-of-Network Utilization. The attachments summarize Dental, STAR and STAR+PLUS out-of-network utilization.

Attachment E – HHSC GeoMapping Summary PCP and ENT (2016SFQ4). The attachment shows the State's GeoMapping analysis for STAR and STAR+PLUS plans.

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

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

Attachment I1-I2 –MCO GeoMapping Summary. The attachment includes the STAR and STAR+PLUS plans' self-reported GeoMapping results for PCP and specialists.

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

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

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

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

Attachments N – MCO Complaints. The attachment includes Dental, STAR and STAR+PLUS complaints and appeals received by plans.

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

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

Attachment Q – Members with Special Healthcare Needs Report (2016 SFQ4). The attachment represents total MSHCN enrollment in STAR and STAR+PLUS during the prior fiscal year.

Attachment R1-R2 – Provider Fraud and Abuse. The attachments represents a summary of the referrals that STAR, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period.

Attachments V1-V3 – Claims Summary (2016 SFQ3 -SFQ4). The attachments are summaries of the MCOs' claims adjudication results.

Attachment W – DSRIP Reporting by RHP. The attachments includes a summary of the demonstration year 3 DSRIP reporting by RHP and annual reports from all anchors

Attachment X - DSRIP Project Summary October DY5. The attachment includes a summary of the accomplishments, progress on core components, and CQI (Continuous Quality Improvement) for each DSRIP project as reported in October 2016.

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Date Submitted to CMS: February 17, 2017

ACRONYM LIST

AAA	Area agency on aging
ADRC	Aging and Disability Resource Centers
APHA	American Public Health Association
BIP	Balancing Incentive Program
CAHPS	Consumer Assessment of Health Providers and Systems
CAP	Corrective action plan
CFC	Community First Choice
CMS	Centers for Medicare & Medicaid Services
DADS	Department of Aging and Disability Services
DMO	Dental managed care organization
DSH	Disproportionate Share Hospital
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration year
EB	Enrollment broker
EG	Evaluation goal
ENT	Otolaryngologist
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
ER	Emergency room
ERS	Emergency response services
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HPM	Health Plan Management
HSRI	Human Services Research Institute
ICF-IID	Intermediate care facility for individuals with intellectual disabilities or a related condition
ICHP	Institute for Child Health Policy
ICSS	Independent Consumer Supports System
IGT	Intergovernmental transfer
IMD	Institution for mental disease
LD	Liquidated damages
LTCO	Long-term care ombudsman
MACPAC	Medicaid and CHIP payment and Access Commission
MAGI	Modified adjusted gross income
MCO	Managed care organization

MMCH	Medicaid Managed Care Helpline
MRSA	Medicaid Rural Service Areas
NASDDDS	National Association of State Directors of Developmental Disabilities Services
NASHP	National Academy for State Health Policy
NASUAD	National Association of States United for Aging and Disabilities
NCI-AD	National Core Indicators-Aging and Disabilities
OON	Out-of-network
P4Q	Pay-For-Quality
PBM	Pharmacy Benefits Manager
PIP	Performance improvement project
PCP	Primary care provider
PFM	Program Funding and Mechanics
RHP	Regional Healthcare Partnerships
SDA	Service delivery area
SDS	HHSC Strategic Decision Support
SFQ	State Fiscal Quarter
SMMC	State Medicaid Managed Care Advisory Committee
SPMI	Severe and persistent mental illness
STCs	Special Terms and Conditions
TCH	Texas Children's Hospital
TCHP	Texas Children's Health Plan
THSteps	Texas Health Steps
UC	Uncompensated care