Texas Healthcare Transformation and Quality Improvement Program

Section 1115 Report

Texas Health and Human Services Commission

Demonstration Reporting Period:

2017 State Fiscal Quarter (SFQ) 4 June 1, 2017 - August 31, 2017

2018 SFQ1, September 1, 201 -November 30, 2017

Demonstration Year (DY) 6 Quarter (Q) 4, July 1, 2017 - September 30, 2017

DY 6 October 1, 2016 - September 30, 2017

DY 7 Q1 October 1, 2017 - December 31, 2017

TABLE OF CONTENTS

I. INTRODUCTION

The Texas Healthcare Transformation and Quality Improvement Program Section 1115 waiver enables 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, STAR Kids, 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(l), 24(l), 26(e), 29, 41(a), (b), and (c), 42 (b) and (c), 43(a), 52, 56, 69, 71, 72, and 75. 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 71 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 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 2017 SFQ4 (June - August) instead of Demonstration Year (DY) 6, Q4 ("D6Q4," covering July - September 2017) and 2018 SFQ1 (September - November) instead of Demonstration Year (DY) 7, Q1 ("D7Q1," covering October - December 2017). Throughout the report, the State has identified whether the quarterly data relates to 2017 SFQ4 and 2018 SFQ1, or D6Q4 and D7Q1.

A. MANAGED CARE PLANS PARTICIPATING IN THE WAIVER PROGRAM

During the 2017 SFQ4 and 2018 SFQ1, the State contracted with 18 STAR, 10 STAR Kids, 5 STAR+PLUS, and 2 Dental program plans. Each health plan covers one or more of the 13 STAR service delivery areas (SDAs), 10 STAR Kids and 13 STAR+PLUS SDAs while each dental plan provides statewide services. Please refer to Attachment A for a list of the STAR, STAR Kids, 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:

1. Monetary damages (actual, consequential, direct, indirect, special, and/or liquidated damages (LDs)),

2. 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 43(a), HHSC has taken the following steps towards compliance:

1. In May 2017, CMS announced an extension deadline for all states to be in compliance with HCBS rules by March 2022. HHSC intends to resubmit the 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 in the summer of 2018.
2. Throughout 2017, HHSC has continued to provide stakeholders with updated information regarding the Texas transition plan and opportunities to answer stakeholder questions. HHSC is developing the compliance plan that will be included in the amended Texas Statewide Settings Transition Plan. Texas plans to resubmit the amended plan in the summer of 2018.
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. 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 to provide incentive payments to participating providers that implement and operate delivery system reforms.

Texas worked with private and public hospitals, local government entities, and other providers to create 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 26(e), 41(a) and (b), 71 including quarterly trends and issues related to STAR, STAR Kids, 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 2017 SFQ1 through 2018 SFQ1 reporting period (September 2016- November 2017) instead of DY6 (October 1, 2016 - September 20, 2017) or DY7 Q1 (October 1, 2017 - December 31, 2017). Supporting data are located in Attachment B.

A.ELIGIBILITY AND ENROLLMENT

This subsection addresses the quarterly reporting requirements found in STC 26(e) and 71. Attachment B includes enrollment summaries for the four 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, STAR Kids, and Dental, increased by .35% from 2017 SFQ3 to SFQ4 and increased by 2.80% from 2017 SFQ4 to 2018 SFQ1.

1. STAR

2017 SFQ4 (June - August)

As shown in the following tables, the number of members enrolled in STAR plans increased by 0.49% from 2,879,362 in 2017 SFQ3 to 2,893,600 in 2017 SFQ4. During 2017 SFQ4, seven MCOs and two SDAs reported decreases in member enrollment but these declines were very small with the largest decrease reported for El Paso 1st MCO (-2.07%) and El Paso SDA (-.56%) . In contrast, the largest increases in member enrollment were reported for Driscoll MCO (1.59%) and Jefferson SDA (2.97%).

Enrollment by STAR MCO (2017 SFQ3 - 2017 SFQ4)

STAR	2017 Q3	2017 Q4	Total Change	Percent Change from SFQ3 2017 to SFQ4 2017
Statewide	**2,879,362**	**2,893,600**	**14,238**	**0.49%**
Aetna	70,116	70,200	84	**0.12%**
Amerigroup	549,286	546,227	(3,059)	**-0.56%**
BCBS	24,799	25,040	241	**0.97%**
CHC	237,994	240,611	2,617	**1.10%**
Christus	5,084	5,025	(59)	**-1.16%**
Community 1st	102,192	102,355	163	**0.16%**
Cook Children's	101,115	102,100	985	**0.97%**
Driscoll	146,866	149,201	2,335	**1.59%**
El Paso 1st	64,165	62,836	(1,329)	**-2.07%**
FirstCare	88,272	87,222	(1,050)	**-1.19%**
Molina	95,633	95,262	(371)	**-0.39%**
Parkland	160,826	161,008	182	**0.11%**
Scott & White	43,867	44,444	577	**1.32%**
Sendero	12,795	12,780	(15)	**-0.12%**
Seton	17,758	17,618	(140)	**-0.79%**
Superior	693,926	702,229	8,303	**1.20%**
Texas Children's	338,704	341,958	3,254	**0.96%**
United	125,964	127,484	1,520	**1.21%**

Enrollment by STAR SDA (2017 SFQ3 - 2017 SFQ4)

STAR	2017 Q3	2017 Q4	Total Change	Percent Change from SFQ3 2017 to SFQ4 2017
Statewide	**2,879,362**	**2,893,600**	14,238	0.49%
Bexar	243,388	246,283	2,895	1.19%
Dallas	383,023	383,354	331	0.09%
El Paso	120,166	119,490	(676)	-0.56%
Harris	692,037	696,976	4,939	0.71%
Hidalgo	348,395	348,434	39	0.01%
Jefferson	75,118	77,352	2,234	2.97%
Lubbock	73,932	74,087	155	0.21%
MRSA Central	131,540	133,808	2,268	1.72%
MRSA Northeast	167,332	168,612	1,280	0.76%
MRSA West	154,871	155,417	546	0.35%
Nueces	87,000	87,648	648	0.74%
Tarrant	262,298	261,833	(465)	-0.18%
Travis	140,262	140,306	44	0.03%

Market Share by STAR MCO (2017 SFQ3 - 2017 SFY Q4)

The STAR market share distribution by MCOs fluctuated slightly from the prior quarter, with less than a percentage point change from 2017 SFQ3 to 2017 SFQ4 for all MCOs, as shown in the table below.

STAR	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Percent Change from SFQ3 2017 to SFQ4 2017
Aetna	2.43%	2.43%	2.44%	2.43%	**-0.01%**
Amerigroup	19.52%	19.32%	19.08%	18.88%	**-0.20%**
BCBS	0.83%	0.86%	0.86%	0.87%	**0.00%**
CHC	8.29%	8.26%	8.27%	8.32%	**0.05%**
Christus	0.19%	0.19%	0.18%	0.17%	**0.00%**
Community 1st	3.63%	3.58%	3.55%	3.54%	**-0.01%**
Cook Children's	3.46%	3.48%	3.51%	3.53%	**0.02%**
Driscoll	5.01%	5.07%	5.10%	5.16%	**0.06%**
El Paso 1st	2.28%	2.24%	2.23%	2.17%	**-0.06%**
FirstCare	3.18%	3.11%	3.07%	3.01%	**-0.05%**
Molina	3.36%	3.32%	3.32%	3.29%	**-0.03%**
Parkland	5.72%	5.66%	5.59%	5.56%	**-0.02%**
Scott & White	1.45%	1.52%	1.52%	1.54%	**0.01%**
Sendero	0.45%	0.46%	0.44%	0.44%	**0.00%**
Seton	0.62%	0.62%	0.62%	0.61%	**-0.01%**
Superior	23.96%	24.04%	24.10%	24.27%	**0.17%**
Texas Children's	11.50%	11.54%	11.76%	11.82%	**0.05%**
United	4.12%	4.31%	4.37%	4.41%	**0.03%**

2018 SFQ1 (September - November)

The number of members enrolled in STAR plans increased by 4.26% from 2,893,600 in 2017 SFQ4 to 3,016,899 in 2018 SFQ1. During 2018 SFQ1, two MCOs reported decreases in member enrollment but these declines were very small with the largest decrease reported for Amerigroup MCO (-0.37%). In contrast, the largest increases in member enrollment were reported for Sendero MCO (14.19%) and MRSA Northeast SDA (9.44%).

Enrollment by STAR MCO (2017 SFQ4 - 2018 SFQ1)

STAR	2017 Q4	2018 Q1	Total Change	Percent Change from SFQ4 2017 to SFQ1 2018
Statewide	**2,893,600**	**3,016,899**	**123,299**	**4.26%**
Aetna	70,200	74,144	3,944	**5.62%**
Amerigroup	546,227	544,230	(1,997)	**-0.37%**
BCBS	25,040	26,660	1,620	**6.47%**
CHC	240,611	252,790	12,179	**5.06%**
Christus	5,025	5,290	265	**5.27%**
Community 1st	102,355	106,390	4,035	**3.94%**
Cook Children's	102,100	108,219	6,119	**5.99%**
Driscoll	149,201	152,360	3,159	**2.12%**
El Paso 1st	62,836	65,196	2,360	**3.76%**
FirstCare	87,222	87,209	(13)	**-0.01%**
Molina	95,262	99,400	4,138	**4.34%**
Parkland	161,008	168,185	7,177	**4.46%**
Scott & White	44,444	44,940	496	**1.12%**
Sendero	12,780	14,594	1,814	**14.19%**
Seton	17,618	18,008	390	**2.21%**
Superior	702,229	746,687	44,458	**6.33%**
Texas Children's	341,958	366,625	24,667	**7.21%**
United	127,484	135,972	8,488	**6.66%**

Enrollment by STAR SDA (2017 SFQ4 - 2018 SFQ1)

STAR	2017 Q4	2018 Q1	Total Change	Percent Change from SFQ4 2017 to SFQ1 2018
Statewide	**2,893,600**	**3,016,899**	**123,299**	**4.26%**
Bexar	246,283	258,033	11,750	**4.77%**
Dallas	383,354	390,937	7,583	**1.98%**
El Paso	119,490	125,946	6,456	**5.40%**
Harris	696,976	740,670	43,694	**6.27%**
Hidalgo	348,434	349,909	1,475	**0.42%**
Jefferson	77,352	82,389	5,037	**6.51%**
Lubbock	74,087	80,012	5,925	**8.00%**
MRSA Central	133,808	138,820	5,012	**3.75%**
MRSA Northeast	168,612	184,531	15,919	**9.44%**
MRSA West	155,417	159,046	3,629	**2.34%**
Nueces	87,648	91,494	3,846	**4.39%**
Tarrant	261,833	267,859	6,026	**2.30%**
Travis	140,306	147,253	6,947	**4.95%**

Market Share by STAR MCO (2017 SFQ4 - 2018 SFQ1)

The STAR market share distribution by MCOs fluctuated slightly from the prior quarter, with less than a percentage point change from 2017 SFQ4 to 2018 SFQ1 for all MCOs, as shown in the table below.

STAR	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Percent Change from SFQ4 2017 to SFQ1 2018
Aetna	2.43%	2.44%	2.43%	2.46%	**0.03%**
Amerigroup	19.32%	19.08%	18.88%	18.04%	**-0.84%**
BCBS	0.86%	0.86%	0.87%	0.88%	**0.02%**
CHC	8.26%	8.27%	8.32%	8.38%	**0.06%**
Christus	0.19%	0.18%	0.17%	0.18%	**0.00%**
Community 1st	3.58%	3.55%	3.54%	3.53%	**-0.01%**
Cook Children's	3.48%	3.51%	3.53%	3.59%	**0.06%**
Driscoll	5.07%	5.10%	5.16%	5.05%	**-0.11%**
El Paso 1st	2.24%	2.23%	2.17%	2.16%	**-0.01%**
FirstCare	3.11%	3.07%	3.01%	2.89%	**-0.12%**
Molina	3.32%	3.32%	3.29%	3.29%	**0.00%**
Parkland	5.66%	5.59%	5.56%	5.57%	**0.01%**
Scott & White	1.52%	1.52%	1.54%	1.49%	**-0.05%**
Sendero	0.46%	0.44%	0.44%	0.48%	**0.04%**
Seton	0.62%	0.62%	0.61%	0.60%	**-0.01%**
Superior	24.04%	24.10%	24.27%	24.75%	**0.48%**
Texas Children's	11.54%	11.76%	11.82%	12.15%	**0.33%**
United	4.31%	4.37%	4.41%	4.51%	**0.10%**

2. STAR Kids

2017 SFQ4 (June - August)

As shown in the following tables, the number of members enrolled in STAR Kids plans decreased by -0.64% from 162,444 in 2017 SFQ3 to 161,401 in 2017 SFQ4. During 2017 SFQ4, six MCOs and ten SDAs reported decreases in member enrollment but these declines were very small with the largest decrease reported for BCBS MCO (-2.32%) and MRSA West SDA (-1.72%). In contrast, the largest increases in member enrollment was reported for Community First MCO (6.44%) and Bexar SDA (1.58%).

Enrollment by STAR Kids MCO (2017 SFQ3 - 2017 SFQ4)

STAR Kids	2017 Q3	2017 Q4	Total Change	Percent Change from SFQ3 2017 to SFQ4 2017
Statewide	**162,444**	**161,401**	**(1,043)**	**-0.64%**
Aetna	5,159	5,050	(109)	**-2.11%**
Amerigroup	27,865	27,323	(542)	**-1.95%**
BCBS	7,810	7,629	(181)	**-2.32%**
CMC	9,580	9,592	12	**0.13%**
Community 1st	7,924	8,434	510	**6.44%**
Cook Children's	8,820	8,921	101	**1.15%**
Driscoll	10,600	10,419	(181)	**-1.71%**
Superior	29,179	28,624	(555)	**-1.90%**
TX Children's	25,410	25,310	(100)	**-0.39%**
United	30,097	30,099	2	**0.01%**

Enrollment by STAR Kids SDA (2017 SFQ3 - 2017 SFQ4)

STAR Kids	2017 Q3	2017 Q4	Total Change	Percent Change from SFQ3 2017 to SFQ4 2017
Statewide	**162,444**	**161,401**	(1,043)	-0.64%
Bexar	14,961	15,197	236	1.58%
Dallas	21,561	21,506	(55)	-0.26%
El Paso	4,924	4,908	(16)	-0.32%
Harris	36,965	36,715	(250)	-0.68%
Hidalgo	22,276	21,909	(367)	-1.65%
Jefferson	4,954	4,973	19	0.38%
Lubbock	3,308	3,284	(24)	-0.73%
MRSA Central	8,628	8,540	(88)	-1.02%
MRSA Northeast	10,954	10,779	(175)	-1.60%
MRSA West	6,957	6,837	(120)	-1.72%
Nueces	5,522	5,449	(73)	-1.32%
Tarrant	13,979	13,971	(8)	-0.06%
Travis	7,455	7,333	(122)	-1.64%

Market Share by STAR KIDs MCO (2017 SFQ3 - 2017 SFQ4)

The STAR Kids market share distribution by MCOs fluctuated slightly from the prior quarter, with all increases and decreases within a half of a percent, as shown in the table below.

STAR Kids	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Percent Change from SFQ3 2017 to SFQ4 2017
Aetna	3.36%	3.25%	3.18%	3.13%	**-0.05%**
Amerigroup	17.69%	17.18%	17.15%	16.93%	**-0.22%**
BCBS	4.90%	4.80%	4.81%	4.73%	**-0.08%**
CMC	5.87%	5.89%	5.90%	5.94%	**0.05%**
Community 1st	5.03%	4.95%	4.88%	5.23%	**0.35%**
Cook Children's	5.15%	5.29%	5.43%	5.53%	**0.10%**
Driscoll	6.76%	6.50%	6.53%	6.46%	**-0.07%**
Superior	17.88%	18.80%	17.96%	17.73%	**-0.23%**
TX Children's	14.91%	15.13%	15.64%	15.68%	**0.04%**
United	18.45%	18.23%	18.53%	18.65%	**0.12%**

The number of members enrolled in STAR KIDS plans increased by 0.80% from 161,401 in 2017 SFQ4 to 162,697 in 2018 SFQ1. During 2018 SFQ1, three MCOs and two SDAs reported decreases in member enrollment but these declines were small with the largest decrease reported for Aetna MCO (-2.81%) and Hidalgo SDA (-0.77%). In contrast, the largest increases in member enrollment was reported for Cook MCO (3.18%) and Lubbock SDA (5.48%).

Enrollment by STAR Kids MCO (2017 SFQ4 - 2018 SFQ1)

STAR Kids	2017 Q4	2018 Q1	Total Change	Percent Change from SFQ4 2017 to SFQ1 2018
Statewide	**161,401**	**162,697**	**1,296**	**0.80%**
Aetna	5,050	4,908	(142)	**-2.81%**
Amerigroup	27,323	27,547	224	**0.82%**
BCBS	7,629	7,685	56	**0.73%**
CMC	9,592	9,487	(105)	**-1.09%**
Community 1st	8,434	8,615	181	**2.15%**
Cook Children's	8,921	9,205	284	**3.18%**
Driscoll	10,419	10,407	(12)	**-0.12%**
Superior	28,624	28,809	185	**0.65%**
TX Children's	25,310	25,665	355	**1.40%**
United	30,099	30,369	270	**0.90%**

Enrollment by STAR Kids SDA (2017 SFQ4 - 2018 SFQ1)

STAR Kids	2017 Q4	2018 Q1	Total Change	Percent Change from SFQ4 2017 to SFQ1 2018
Statewide	**161,401**	**162,697**	**1,296**	**0.80%**
Bexar	15,197	15,459	262	**1.72%**
Dallas	21,506	21,693	187	**0.87%**
El Paso	4,908	4,951	43	**0.88%**
Harris	36,715	37,015	300	**0.82%**
Hidalgo	21,909	21,741	(168)	**-0.77%**
Jefferson	4,973	4,972	(1)	**-0.02%**
Lubbock	3,284	3,464	180	**5.48%**
MRSA Central	8,540	8,694	154	**1.80%**
MRSA Northeast	10,779	10,892	113	**1.05%**
MRSA West	6,837	6,898	61	**0.89%**
Nueces	5,449	5,465	16	**0.29%**
Tarrant	13,971	14,113	142	**1.02%**
Travis	7,333	7,340	7	**0.10%**

Market Share by STAR KIDs MCO (2017 SFQ4 - 2018 SFQ1)

The STAR Kids market share distribution by MCOs fluctuated from the prior quarter, with increases and decreases under a quarter of a percent, as shown in the table below.

STAR Kids	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Percent Change from SFQ4 2017 to SFQ1 2018
Aetna	3.25%	3.18%	3.13%	3.02%	**-0.11%**
Amerigroup	17.18%	17.15%	16.93%	16.93%	**0.00%**
BCBS	4.80%	4.81%	4.73%	4.72%	**0.00%**
CMC	5.89%	5.90%	5.94%	5.83%	**-0.11%**
Community 1st	4.95%	4.88%	5.23%	5.30%	**0.07%**
Cook Children's	5.29%	5.43%	5.53%	5.66%	**0.13%**
Driscoll	6.50%	6.53%	6.46%	6.40%	**-0.06%**
Superior	18.80%	17.96%	17.73%	17.71%	**-0.03%**
TX Children's	15.13%	15.64%	15.68%	15.77%	**0.09%**
United	18.23%	18.53%	18.65%	18.67%	**0.02%**

3. STAR+PLUS

2017 SFQ4 (June - August)

As shown in the following tables, the number of members enrolled in STAR+PLUS plans increased by 0.66% from 521,638 in 2017 SFQ3 to 525,059 in 2017 SFQ4. During 2017 SFQ4, three SDAs reported decreases in member enrollment and there were no decreases reported by the plans. The three SDA declines were very small with the largest decrease reported for Lubbock SDA (-.62%). In contrast, the largest increases in member enrollment were reported for United MCO (1.45%) and Harris SDA (1.39%).

Enrollment by STAR+PLUS MCO (2017 SFQ3 - 2017 SFQ4)

STAR+PLUS	2017 Q3	2017 Q4	Total Change	Percent Change from SFQ3 2017 to SFQ4 2017
Statewide	**521,638**	**525,059**	**3,421**	**0.66%**
Amerigroup	132,914	133,290	376	**0.28%**
Cigna	49,867	49,959	92	**0.18%**
Molina	86,624	86,952	328	**0.38%**
Superior	138,013	138,978	965	**0.70%**
United	114,220	115,880	1,660	**1.45%**

Enrollment by STAR+PLUS SDA (2017 SFQ3 - 2017 SFQ4)

STAR+PLUS	2017 Q3	2017 Q4	Total Change	Percent Change from SFQ3 2017 to SFQ4 2017
Statewide	**521,638**	**525,059**	**3,421**	**0.66%**
Bexar	45,030	45,420	390	**0.87%**
Dallas	61,280	61,814	534	**0.87%**
El Paso	20,388	20,425	37	**0.18%**
Harris	100,592	101,992	1,400	**1.39%**
Hidalgo	63,985	64,283	298	**0.47%**
Jefferson	19,591	19,616	25	**0.13%**
Lubbock	13,262	13,180	(82)	**-0.62%**
MRSA Central	29,374	29,512	138	**0.47%**
MRSA Northeast	45,296	45,366	70	**0.15%**
MRSA West	37,175	37,164	(11)	**-0.03%**
Nueces	21,210	21,180	(30)	**-0.14%**
Tarrant	39,334	39,873	539	**1.37%**
Travis	25,121	25,234	113	**0.45%**

Market Share by STAR+PLUS MCO (2017 SFQ3 to 2017 SFQ4)

The STAR+PLUS market share distribution by MCOs fluctuated slightly, under one percentage point for all MCOS, from the prior quarter, as shown in the chart below.

STAR+PLUS	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Percent Change from SFQ3 2017 to SFQ4 2017
Amerigroup	25.70%	25.42%	25.48%	25.39%	**-0.09%**
Cigna	9.50%	9.69%	9.56%	9.51%	**-0.04%**
Molina	16.69%	16.54%	16.61%	16.56%	**-0.05%**
Superior	26.48%	26.55%	26.46%	26.47%	**0.01%**
United	21.64%	21.80%	21.90%	22.07%	**0.17%**

2018 SFQ1 (September - November)

The number of members enrolled in STAR+PLUS plans increased by 0.61% from 525,059 in 2017 SFQ4 to 528,255 in 2018 SFQ1. During 2018 SFQ1, two MCOs and one SDA reported decreases in member enrollment. The largest MCO decrease occurred with Amerigroup (-0.53%). In contrast, the largest increases in member enrollment were reported for Superior MCO (0.70%) and El Paso SDA (1.59%).

Enrollment by STAR+PLUS MCO (2017 SFQ4 - 2018 SFQ1)

STAR+PLUS	2017 Q4	2018 Q1	Total Change	Percent Change from SFQ4 2017 to SFQ1 2018
Statewide	**525,059**	**528,255**	**3,196**	**0.61%**
Amerigroup	133,290	132,584	(706)	**-0.53%**
Cigna	49,959	49,774	(185)	**-0.37%**
Molina	86,952	87,506	554	**0.64%**
Superior	138,978	139,948	970	**0.70%**
United	115,880	118,443	2,563	**2.21%**

Enrollment by STAR+PLUS SDA (2017 SFQ4 - 2018 SFQ1)

STAR+PLUS	2017 Q4	2018 Q1	Total Change	Percent Change from SFQ4 2017 to SFQ1 2018
Statewide	**525,059**	**528,255**	**3,196**	**0.61%**
Bexar	45,420	45,552	132	**0.29%**
Dallas	61,814	61,931	117	**0.19%**
El Paso	20,425	20,750	325	**1.59%**
Harris	101,992	102,662	670	**0.66%**
Hidalgo	64,283	63,872	(411)	**-0.64%**
Jefferson	19,616	19,750	134	**0.68%**
Lubbock	13,180	13,296	116	**0.88%**
MRSA Central	29,512	29,913	401	**1.36%**
MRSA Northeast	45,366	46,008	642	**1.42%**
MRSA West	37,164	37,503	339	**0.91%**
Nueces	21,180	21,359	179	**0.85%**
Tarrant	39,873	40,122	249	**0.62%**
Travis	25,234	25,537	303	**1.20%**

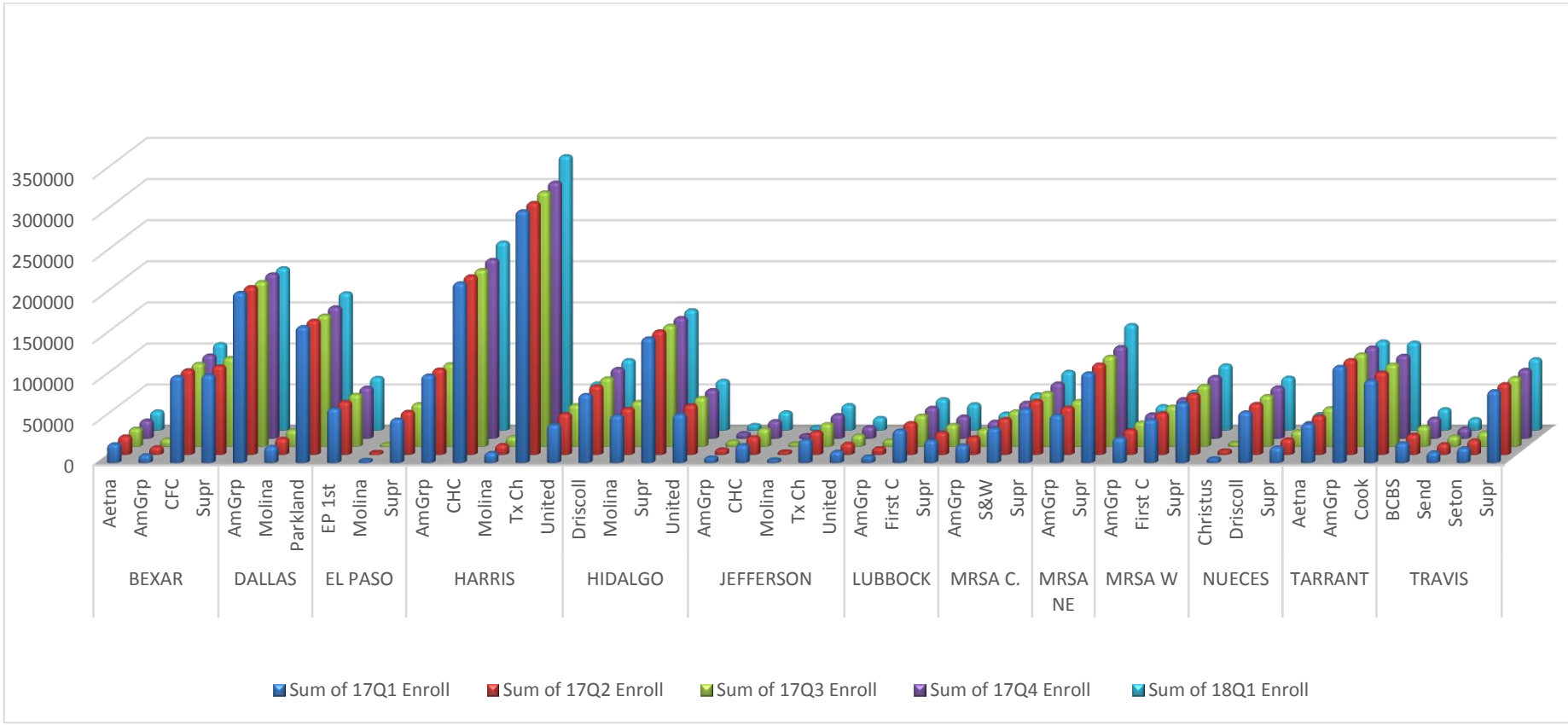
Market Share by STAR+PLUS MCO (2017 SFQ4 to 2018 SFQ1)

The STAR+PLUS market share distribution by MCOs fluctuated a small amount from the prior quarter, with the largest decrease for Amerigroup (-0.29%) and largest increase for United (0.35%), as shown in the chart below.

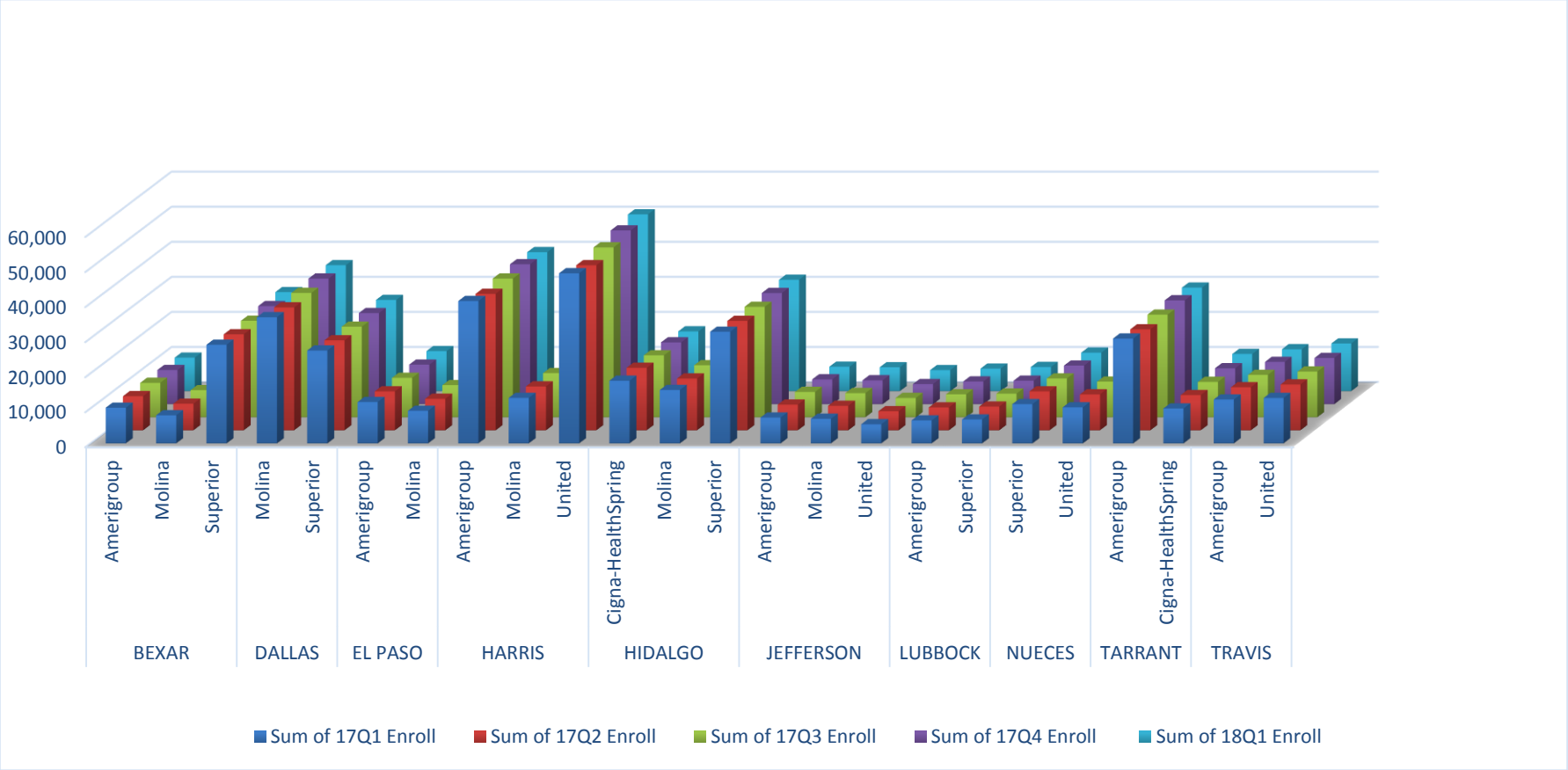
STAR+PLUS	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Percent Change from SFQ4 2017 to SFQ1 2018
Amerigroup	25.42%	25.48%	25.39%	25.10%	**-0.29%**
Cigna	9.69%	9.56%	9.51%	9.42%	**-0.09%**
Molina	16.54%	16.61%	16.56%	16.57%	**0.005%**
Superior	26.55%	26.46%	26.47%	26.49%	**0.02%**
United	21.80%	21.90%	22.07%	22.42%	**0.35%**

The following graphs show STAR, STAR Kids and STAR+PLUS quarterly enrollment by MCO and SDA from 2017 SFQ1 to 2018 SFQ1.

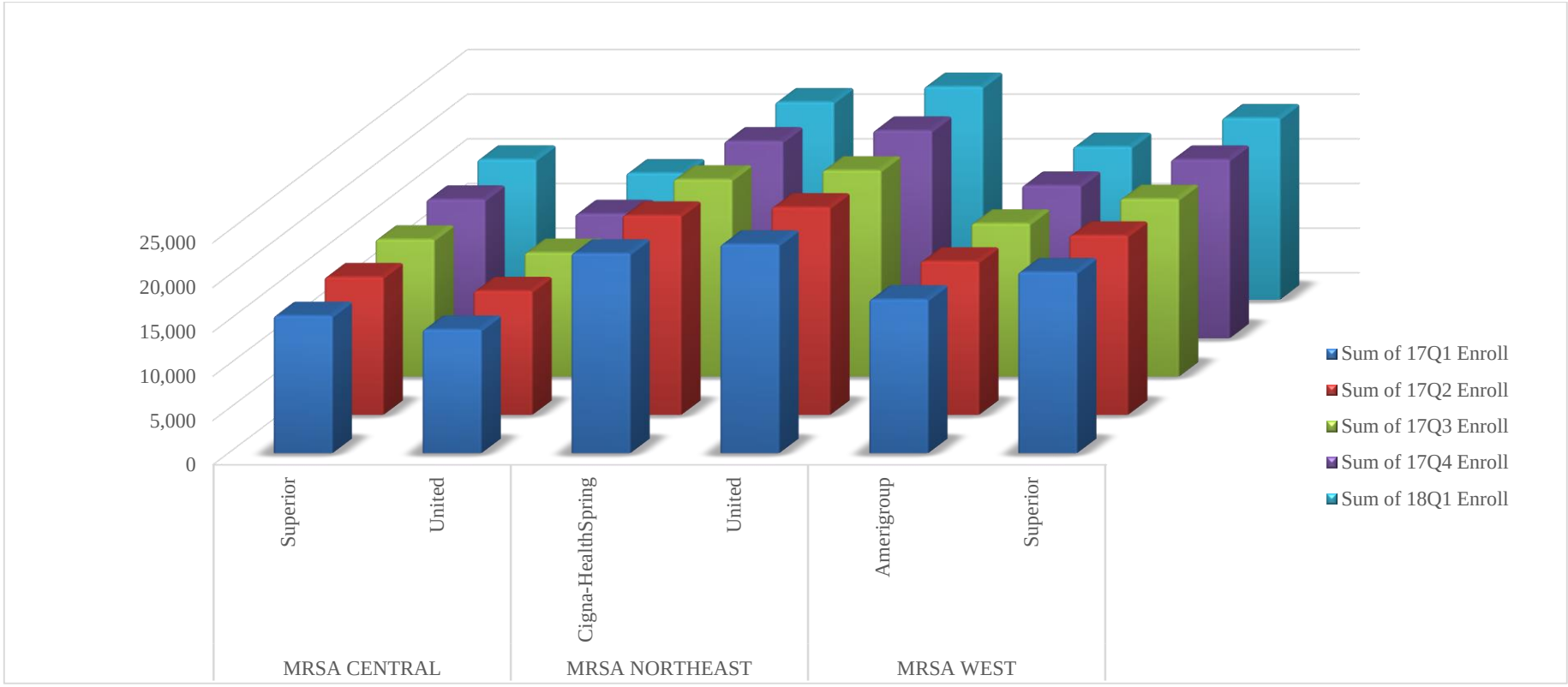
STAR Program Enrollment by MCO and Service Delivery Area (2017 SFQ1 - 2018 SFQ1)



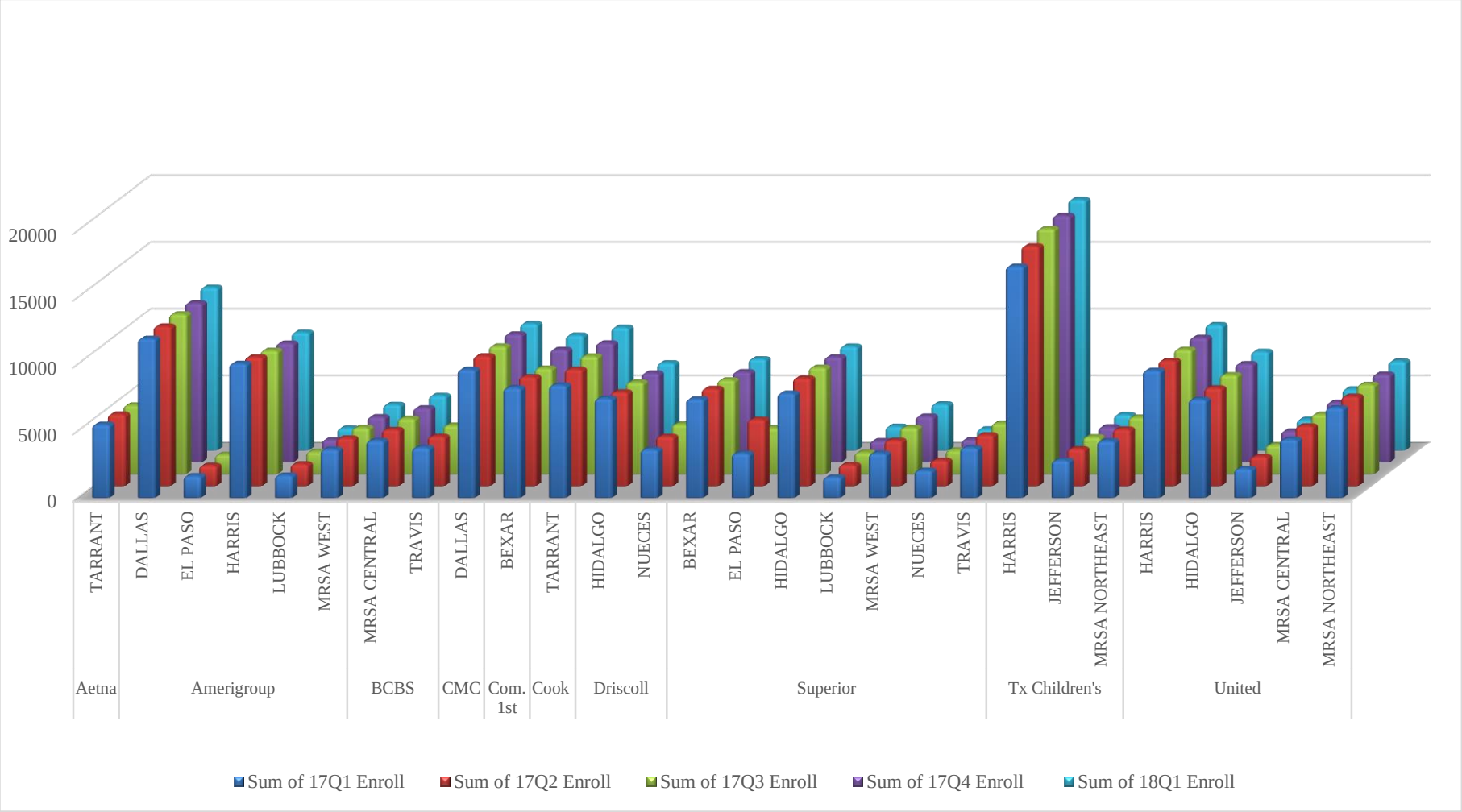
STAR+PLUS Non-MRSA Program Enrollment by MCO and Service Delivery Area (2017 SFQ1 - 2018 SFQ1)



STAR+PLUS MRSA Program Enrollment by MCO and Service Delivery Area (SFY2017 Q1 through 2018 SFQ1)



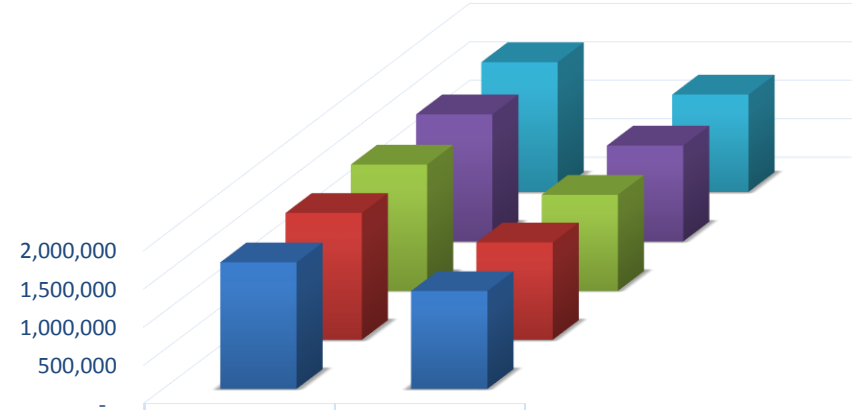
STAR Kids Program Enrollment by MCO and Service Delivery Area (SFY2017 Q1 through 2018 SFQ1)



4. Dental Program

Total enrollment in the Dental Program increased by 0.21% to 2,895,363 members during 2017 SFQ4 and increased by 1.85% to 2,948,985 in 2018 SFQ1.

Dental Program Enrollment Statewide (2017 SFQ1 - 2018 SFQ1)



	DentaQuest	MCNA
	Statewide	
Sum of 17Q1 Enroll	1,657,075	1,283,281
Sum of 17Q2 Enroll	1,655,850	1,272,339
Sum of 17Q3 Enroll	1,640,658	1,248,603
Sum of 17Q4 Enroll	1,650,337	1,245,026
Sum of 18Q1 Enroll	1,685,144	1,263,841

Dental Market Share Statewide (2017 SFQ3 to 2017 SFQ4)

Market share change in the Dental Program remained steady with DentaQuest having 57% while MCNA had 43%.

Dental	2017 Q1	2017 Q2	2017 Q3	2017 Q4	Percentage Point Change from 2017 Q3 to 2017 Q4
DentaQuest	56.36%	56.55%	56.78%	57.00%	0.22%
MCNA	43.64%	43.45%	43.22%	43.00%	-0.22%

Dental Market Share Statewide (2017 SFQ4 to 2018 SFQ1)

Market share change in the Dental Program remained steady with DentaQuest having 57.14% while MCNA had 42.86%.

Dental	2017 Q2	2017 Q3	2017 Q4	2018 Q1	Percentage Point Change from 2017 Q4 to 2018 Q1
DentaQuest	56.55%	56.78%	57.00%	57.14%	**0.14%**
MCNA	43.45%	43.22%	43.00%	42.86%	**-0.14%**

B. ENROLLMENT COUNTS FOR THE QUARTER BY POPULATION

This subsection includes quarterly enrollment counts as required by STC 71. Due to the time required for the data collection process, unique member counts per quarter are reported on a two-quarter lag. Enrollment counts are based on persons and not member months.

Enrollment Counts (DY6 Q2 January - March 2017)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	334,522
Children	2,817,323
Aged and Medicare Related (AMR) (non MRSA - pre Sep14)	382,502
Disabled	433,431

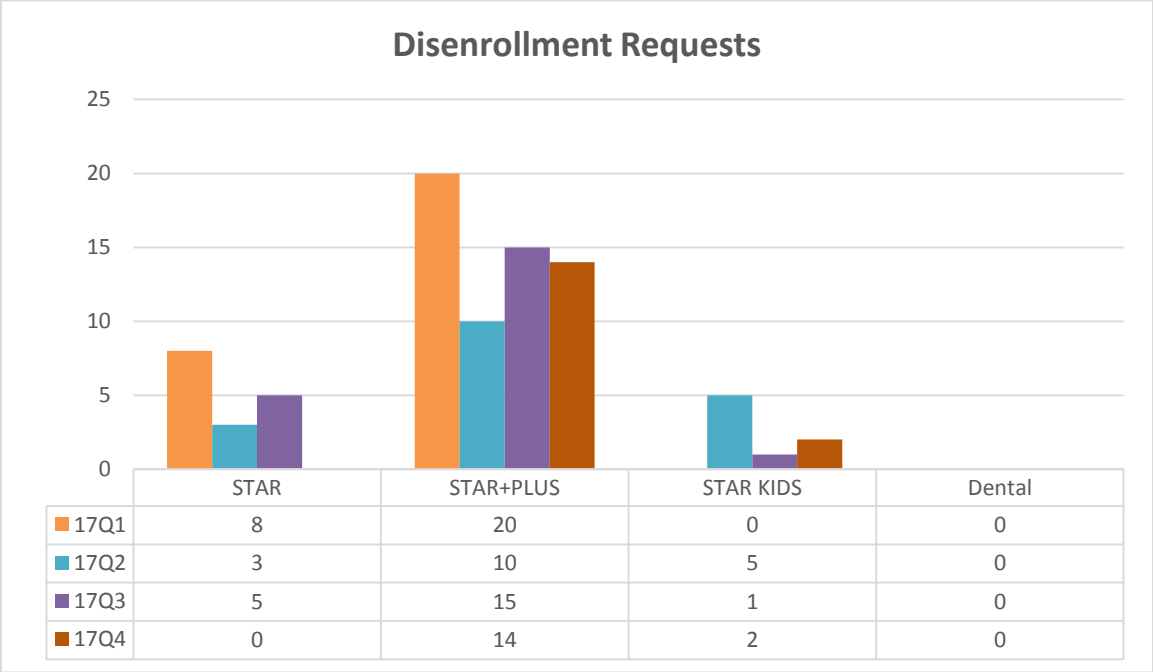
Enrollment Counts (DY6 Q3 April - June 2017)

Enrollment Counts (Demonstration Populations)	Total Number Served
Adults	334,438
Children	2,780,078
AMR (non MRSA - pre Sep14)	382,506
Disabled	433,796

C. DISENROLLMENT

This subsection of the report addresses STC 41(b). In 2017 SFQ3 and SFQ4, the enrollment broker, MAXIMUS, reported 2,702 plan changes processed. Attachment L contains more information about enrollment outreach activities.

Medicaid managed care to the fee-for-service (FFS) delivery model, the State received the following in 2017 SFQ3 and SFQ4: 5 disenrollment requests for STAR, 29 for STAR+PLUS, 3 for STAR Kids and none for the Dental Program. For 2017Q4, the majority of requests for disenrollment were initiated by the Members or their representatives and one request was initiated by the MCO.



	STAR	STAR+PLUS	STAR KIDS	Dental
17Q1	8	20	0	0
17Q2	3	10	5	0
17Q3	5	15	1	0
17Q4	0	14	2	0

D. ENROLLMENT OF MEMBERS WITH SPECIAL HEALTH CARE NEEDS

This subsection of the report addresses STC 41 (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. 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.

STAR is the managed care program for most people in Texas Medicaid, including low-income children and caretaker relatives, pregnant women, Former Foster Care Children, and children and youth receiving Adoption Assistance benefits. STAR Kids is the managed care program for children and youth with disabilities. STAR+PLUS is the managed care program for adults with disabilities and those age 65 and older.

All STAR Kids and STAR+PLUS members are deemed to be MSHCN. Contract language requires STAR managed care organizations (MCOs) to include additional populations to the groups that must be identified as MSHCN including pregnant women identified as high risk, Former Foster Care Children, and Early Childhood Intervention program participants. There are also contractual requirements regarding service management and service coordination, 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 in STAR for 2017 State Fiscal Quarter 4 (2017 SFQ4). HHSC has established contractual requirements and a template for the MCOs to submit MSHCN data on a quarterly basis.

2. Analysis

All STAR Kids and STAR+PLUS plans reported 100% MSHCN, as required in the contract. STAR Kids and STAR+PLUS plans are required to provide service coordination for all members. In 2017 SFQ4, STAR MCOs reported a total of 43,971 children and adults identified as MSHCN, which is 1.52% of all STAR members. See Attachment Q for detail by service delivery area (SDA) and MCO.

STAR MCOs reported 19.86% of MSHCN with service plans in 2017 SFQ4. The overall percentage of STAR MSHCN with service plans has decreased since the last reporting period.

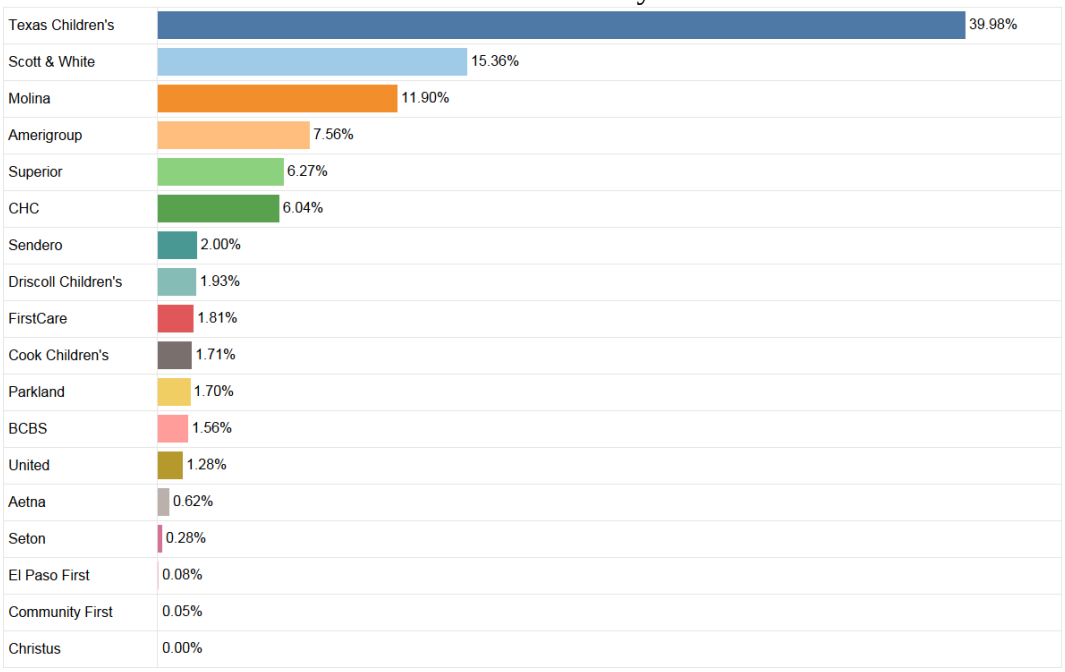
Aetna, Christus, Parkland, and United all reported 100% of MSHCN with service plans. Additionally, two other plans reported more than 90% of MSHCN with service plans (Cook with 99.33% and Superior with 97.32%). Three plans reported fewer than 3% of MSHCN with service plans (Texas Children's with 2.17%, Molina with 1.87%, and Sendero with 1.02%). Community First Health Plan reported that all 22 of its MSHCN declined service management and thus do not have a service plan in place. HHSC has made modifications to the MCO report template to collect data on reasons service plans are not in place. This information will be available for SFY 2018 and beyond.

Approximately 43.64% (19,168) of all STAR MSHCN are concentrated in the Harris SDA. In 2017 SFQ4, Texas Children's reported the largest number (17,556) of MSCHN. Scott & White reported the highest percent of enrollment (15.17%) identified as MSHCN. Please see bar charts below to provide an illustration of the breakdown of MSHCN members by SDA and MCO. Four other STAR plans reported more than 2% of members classified as MSHCN: Blue Cross (2.73%), Molina (5.49%), Sendero (6.89%), and Texas Children's (5.13%). Community Health Choice reported 1.10% of members as MSHCN. The remaining plans reported less than 1 percent of members as MSHCN.

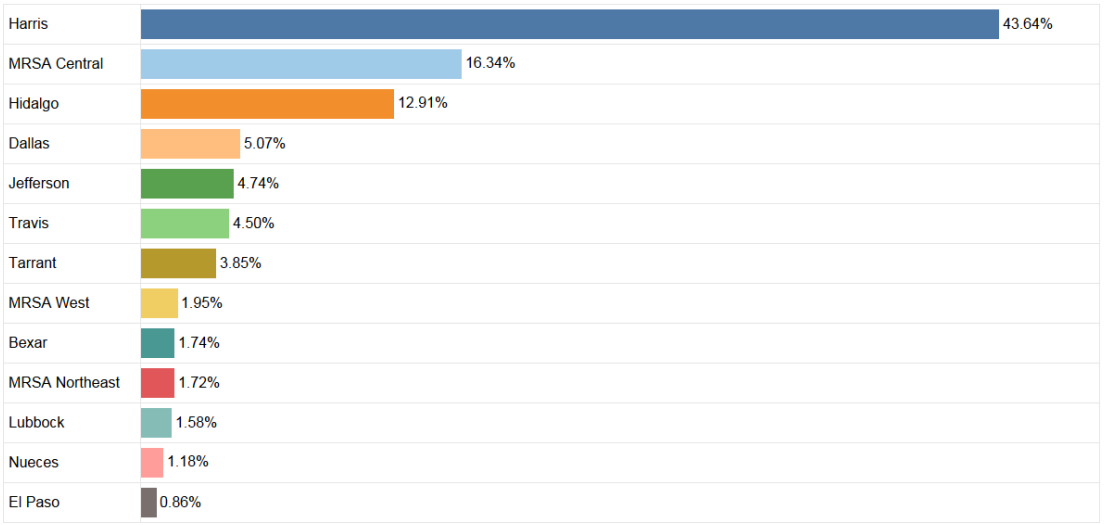
STAR MCOs rely on various mechanisms to identify and verify MSHCN in addition to member self-identification. HHSC does not provide MCOs an all-inclusive list of conditions that should be included in MSHCN criteria. Most STAR MCOs employ a combination of methods including provider referrals, risk assessments, 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 decreased since the last reporting period. For example, some plans reported implementing member survey processes to verify MSHCN status.

Total STAR MSHCN by MCO



Total STAR MSHCN by SDA



E. MEDICAID ELIGIBILITY CHANGES

There are no upcoming Medicaid eligibility changes.

F. ANTICIPATED CHANGES IN POPULATIONS OR BENEFITS

There are no anticipated changes in populations or benefits to report at this time.

III. DELIVERY NETWORKS AND ACCESS

This subsection addresses the quarterly and annual reporting requirements found in STCs 26(e), 41(a), 42(b) and 71. Supporting data is located in Attachments C through J. 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. 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.

2017 SFQ4 (June - August)

Across the STAR program statewide, the MCOs reported a total of 20,391 unique PCP providers, an increase of 453 (2.27%) from the prior quarter. The MCOs reported 16,134 unique PCP providers in the STAR+PLUS program statewide, an increase of 739 (4.8%) from the prior quarter. In the STAR Kids program, MCOs reported a statewide total of 15,417 unique PCP providers, an increase of 634 (4.29%) from the prior quarter.

2018 SFQ1 (September - November)

Across the STAR program statewide, the MCOs reported a total of 20,880 unique PCP providers, an increase of 459 (2.4%) from the prior quarter. The MCOs reported 17,156 unique PCP providers in the STAR+PLUS program statewide, an increase of 1022 (6.33%) from the prior quarter. In the STAR Kids program, MCOs reported a statewide total of 16,020 unique PCP providers, an increase of 603 (3.91%) from the prior quarter.

2. Specialists (non-pharmacy)

2017 SFQ4 (June - August)

Across the STAR program statewide, the MCOs reported 56,997 unique specialty providers, a decrease of 738 (1.28%) from the prior quarter. The MCOs reported 48,956 unique specialty providers in the STAR+PLUS program statewide, a decrease of 1820 (3.41%) providers from the previous quarter. In the STAR Kids program, MCOs reported a statewide total of 44,547 unique specialty providers, an increase of 1820 (4.26%) from the prior quarter.

2018 SFQ1 (September - November)

Statewide STAR program, MCOs reported 59,076 unique specialty providers, an increase of 2,079 (3.65%) from the prior quarter. The MCOs reported 52,000 unique specialty providers in the STAR+PLUS program statewide, an increase of 2,144 (4.3%) providers from the previous quarter. In the STAR Kids program, MCOs reported a statewide total of 47,277 unique specialty providers, an increase of 2,730 (6.13%) from the prior quarter.

3. Provider Terminations

Attachment C3 details data reported by the MCOs regarding the number of PCPs and specialists terminated in 2017 SFQ4 and 2018 SFQ1. 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

2017 SFQ4 (June - August)

Across the STAR program statewide, the MCOs reported a total of 4,931 unique pharmacies, an increase of 27 (0.55%) pharmacies from the prior quarter. The MCOs reported 4,777 unique pharmacies in the STAR+PLUS program statewide, a decrease of 2 (-0.04%) pharmacies from the prior quarter. In the STAR Kids program, MCOs reported a statewide total of 4,860 unique pharmacies, an increase of 26 (.54%) from the prior quarter.

2018 SFQ1 (September - November)

Across the STAR program statewide, the MCOs reported a total of 4,990 unique pharmacies, an increase of 59 (1.2%) pharmacies from the prior quarter. The MCOs reported 4,855 unique pharmacies in the STAR+PLUS program statewide, an increase of 78 (-0. 04%) pharmacies from the prior quarter. In the STAR Kids program, MCOs reported a statewide total of 4,910 unique pharmacies, an increase of 50 (1.03%) from the prior quarter.

All MCOs contract with pharmacies outside their primary SDA to ensure members have access to a pharmacy if they travel outside the SDA.

5. Dental Program Provider Counts

2017 SFQ4 (June - August)

In 2017 SFQ4, DentaQuest reported a total of 5,516 unique dental providers, an increase of 71 (1.3%) dental providers from the prior quarter. MCNA reported 4,366 unique dental providers, an increase of 101 (2.36%) dental providers from the prior quarter.

2018 SFQ1 (September - November)

In 2018 SFQ1, DentaQuest reported a total of 4,364 unique dental providers, a decrease of 1,152 (20.88%) dental providers from the prior quarter. MCNA reported 4,491 unique dental providers, an increase of 125 (2.86%) dental providers from the prior quarter.

B. PROVIDER OPEN PANEL

This section addresses annual reporting requirements found in STC 26(e) and 42(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. 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.

STAR, STAR+PLUS, STAR Kids Statewide

Across all programs, open panel PCP rates remained steady above the 80% benchmark in FY2017 SFQ4.

STAR, STAR+PLUS and STAR Kids by SDA

Throughout 2017 in the STAR and STAR Kids programs, all of the service delivery areas maintained open panel PCP rates above the 80% benchmark. In the STAR+PLUS program, open panel PCP rates fell below the 80% benchmark for all quarters in the Travis SDA.

STAR, STAR Kids, and STAR+PLUS by MCO

Across the STAR program, all but two MCOs open panel PCP rates remained steady above the 80% benchmark in 2017 SFQ4. Both Cook Children's and Texas Children's were below the benchmark for all 2017 quarters. In the STAR Kids program, the open panel PCP rate was above the 80% benchmark for all MCOs except one.

Although Cook Children's did not meet the benchmark for FY2017 for the STAR nor STAR Kids programs, the plan contracts with several PCPs that elect to maintain a closed panel. The PCPs provide services to a certain number of Medicaid clients as well as other clients not enrolled in these programs. In addition, Cook Children's has the flexibility of working with certain PCPs with a closed panel to agree to take on new members; this is normally achieved on a case-by-case basis. This agreement has allowed Cook Children's to maintain these providers. Texas Children's also works with several providers that chose to have a closed panel and Texas' Children's continues to work with providers to maintain open panels in order to meet member needs.

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

Dental Program

Both dental plans met the state's 90% benchmark for main dentists with open practices in every fiscal quarter of 2017.

PCP Open Panel by MCO

Program	MCO Name	Q1 2017	Q2 2017	Q3 2017	Q4 2017
STAR	Aetna	93.76%	93.85%	94.13%	94.40%
	Amerigroup	87.46%	87.18%	87.08%	87.34%
	BCBS	93.53%	93.08%	93.61%	94.32%
	CHC	91.55%	92.45%	88.97%	89.21%
	Christus	100.00%	100.00%	98.45%	96.40%
	Community First	91.94%	92.30%	92.51%	92.58%
	Cook Children's	63.93%	63.60%	65.33%	66.97%
	Driscoll Children's	98.21%	98.05%	98.08%	98.20%
	El Paso First	92.81%	92.59%	92.71%	93.39%
	FirstCare	88.82%	88.99%	89.25%	90.36%
	Molina	92.42%	92.67%	92.69%	92.57%

	Parkland	95.19%	95.40%	95.59%	95.76%
	Scott & White	88.62%	88.27%	87.35%	87.85%
	Sendero	93.44%	93.74%	93.75%	93.69%
	Seton	100.00%	99.39%	99.25%	98.76%
	Superior	84.83%	85.54%	85.78%	86.29%
	Texas Children's	78.40%	79.00%	77.71%	77.45%
	United	94.28%	94.28%	88.31%	89.07%
STAR+PLUS	Amerigroup	85.25%	85.19%	85.16%	85.57%
	Cigna-HealthSpring	91.04%	89.98%	89.00%	89.84%
	Molina	90.95%	90.94%	91.02%	91.32%
	Superior	82.14%	83.20%	83.57%	84.23%
	United	94.33%	94.25%	90.56%	90.61%
STAR Kids	Aetna	100.00%	100.00%	100.00%	100.00%
	Amerigroup	97.18%	92.82%	92.26%	92.55%
	BCBS	96.15%	95.99%	95.88%	96.47%
	Children's Medical Center	100.00%	100.00%	100.00%	100.00%
	Community First	90.00%	90.08%	89.70%	90.08%
	Cook Children's	60.76%	61.77%	65.54%	67.34%
	Driscoll Children's	98.23%	97.96%	96.34%	96.38%
	Superior	87.54%	89.70%	90.83%	90.99%
	Texas Children's	96.60%	94.32%	84.78%	84.87%
	United	97.59%	96.97%	95.25%	93.23%

PCP Open Panel by SDA

Program	SDA	Q1 2017	Q2 2017	Q3 2017	Q4 2017
STAR	Bexar	91.37%	91.48%	91.68%	91.86%
	Dallas	91.60%	90.59%	89.88%	90.08%
	El Paso	97.44%	97.98%	97.91%	98.17%
	Harris	93.80%	93.75%	93.33%	93.53%
	Hidalgo	97.50%	97.55%	97.52%	97.46%
	Jefferson	93.91%	93.98%	92.21%	92.48%
	Lubbock	92.49%	92.43%	92.92%	92.84%
	MRSA C	83.99%	83.93%	84.32%	84.46%
	MRSA N	88.43%	88.16%	88.05%	88.45%
	MRSA W	87.90%	87.99%	88.34%	87.74%
	Nueces	97.32%	97.89%	97.22%	96.85%

	Tarrant	88.93%	88.09%	87.23%	87.81%
	Travis	93.60%	93.81%	93.69%	94.08%
STAR+PLUS	Bexar	84.14%	84.73%	85.46%	85.96%
	Dallas	83.66%	84.51%	84.76%	85.74%
	El Paso	96.27%	96.14%	96.29%	95.94%
	Harris	93.34%	92.98%	91.30%	91.74%
	Hidalgo	97.35%	97.41%	97.15%	97.17%
	Jefferson	92.47%	92.27%	90.35%	90.68%
	Lubbock	91.51%	91.58%	91.88%	92.05%
	MRSA C	80.97%	82.41%	83.00%	83.65%
	MRSA N	95.78%	93.88%	93.22%	93.08%
	MRSA W	91.35%	91.92%	92.37%	92.51%
	Nueces	95.73%	96.09%	95.67%	95.75%
	Tarrant	83.02%	81.96%	81.57%	82.57%
	Travis	77.50%	78.29%	78.02%	79.12%
STAR Kids	Bexar	81.07%	83.08%	86.48%	87.17%
	Dallas	98.39%	88.85%	88.12%	88.54%
	El Paso	96.85%	96.95%	97.60%	97.75%
	Harris	98.33%	97.36%	94.32%	93.20%
	Hidalgo	97.89%	97.95%	97.45%	97.57%
	Jefferson	94.23%	93.73%	85.79%	82.43%
	Lubbock	92.44%	94.89%	96.04%	96.01%
	MRSA C	97.40%	97.31%	97.08%	97.26%
	MRSA N	99.03%	97.94%	97.42%	96.80%
	MRSA W	92.75%	93.98%	94.43%	94.81%
	Nueces	96.54%	96.86%	96.38%	96.21%
	Tarrant	95.34%	95.83%	93.51%	93.57%
	Travis	93.69%	93.59%	93.73%	94.44%

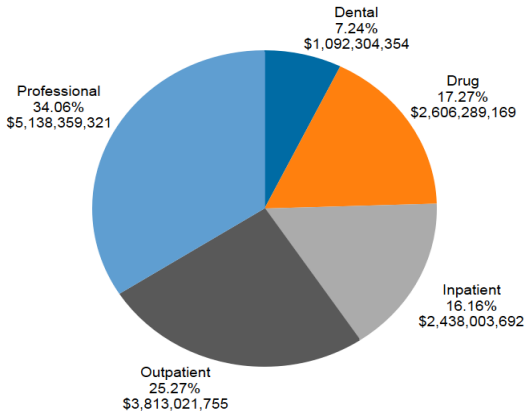
C. SERVICE UTILIZATION

This subsection addresses annual reporting requirements found in STC 26(e). Analysis of service utilization is completed using SFY 2016 acute care services and pharmacy services encounter data. Long term services and supports are not included and expenditures represent the amount the MCO reimbursed the provider.

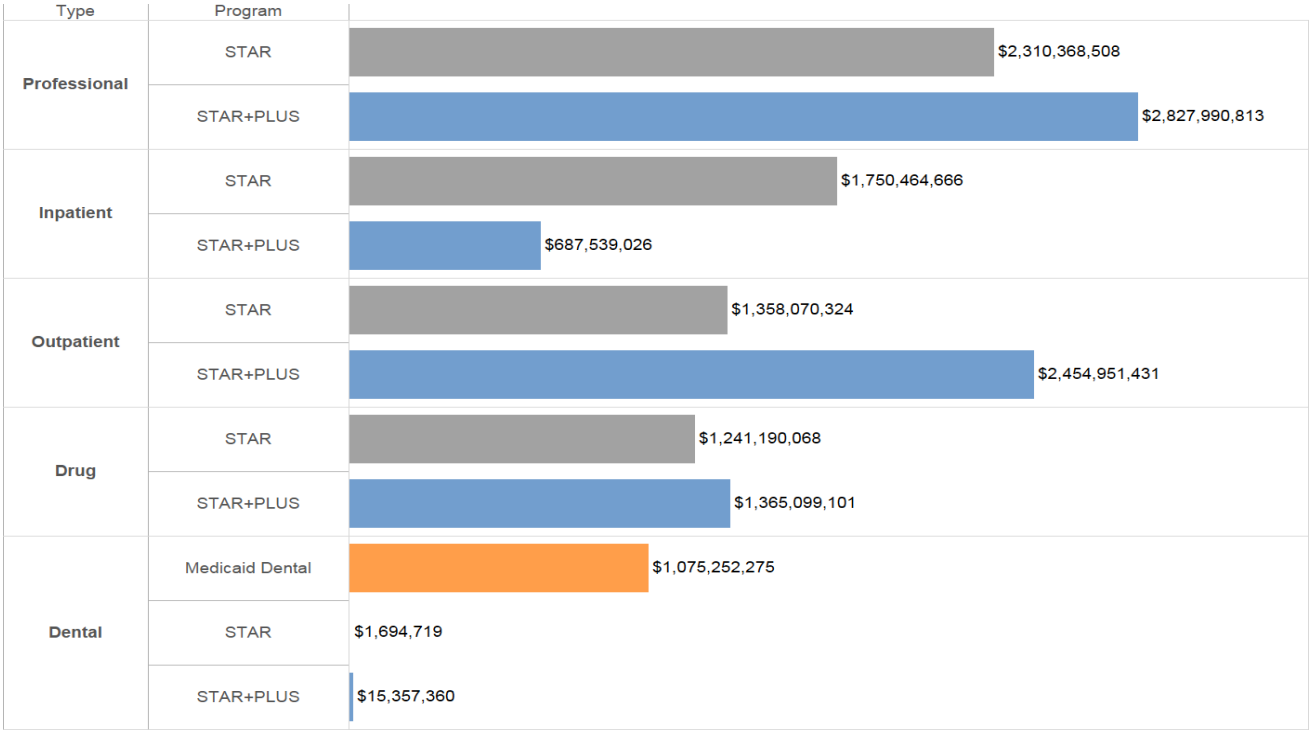
Depicted in the figures below, professional claims made up over 34.06% of the total expenditures in STAR and STAR+PLUS in SFY 2016. "Inpatient" refers to inpatient hospital services and "outpatient" refers to services received at a hospital on an outpatient basis and at non-hospital

facilities. Professional claims account for about one-third of expenditures.

Expenditures by Claim Type (2016)



Expenditures by Program and Claim Type (2016)



Expenditures by SDA (2016)

SDA	Total Expenditures	
Harris	$2,959,007,722	21.12%
Hidalgo	$1,892,065,473	13.50%
Dallas	$1,687,344,077	12.04%
Bexar	$1,216,359,688	8.68%
Tarrant	$1,186,389,509	8.47%
MRSA Northeast	$1,012,235,196	7.22%
MRSA West	$812,909,149	5.80%
Travis	$707,879,617	5.05%
MRSA Central	$684,495,154	4.88%
Nueces	$583,015,735	4.16%
El Paso	$477,903,048	3.41%
Jefferson	$452,308,770	3.23%
Lubbock	$340,812,877	2.43%

Average Monthly STAR Enrollment and Expenditures by SDA (2016)

SDA	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditures
Harris	698,519	23.63%	$132,841,519	23.93%
Hidalgo	361,885	12.24%	$68,142,043	12.27%
Dallas	404,892	13.70%	$73,418,330	13.22%
Tarrant	269,594	9.12%	$49,353,359	8.89%
Bexar	252,611	8.54%	$48,198,155	8.68%
MRSA Northeast	168,607	5.70%	$31,265,911	5.63%
MRSA West	155,222	5.25%	$28,782,545	5.18%
MRSA Central	131,470	4.45%	$23,160,228	4.17%
Travis	148,106	5.01%	$27,387,145	4.93%
El Paso	126,299	4.27%	$20,811,446	3.75%
Nueces	86,368	2.92%	$21,390,971	3.85%
Lubbock	76,580	2.59%	$14,473,796	2.61%
Jefferson	76,201	2.58%	$15,923,576	2.87%

Average Monthly STAR+PLUS Enrollment and Expenditures by SDA (2016)

SDA	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditures
Harris	103,212	19.22%	$113,742,458	18.57%
Hidalgo	67,805	12.63%	$89,530,080	14.62%
Dallas	61,727	11.50%	$67,193,677	10.97%
Bexar	47,041	8.76%	$53,165,153	8.68%
MRSA Northeast	46,464	8.65%	$53,087,022	8.67%
Tarrant	39,627	7.38%	$49,512,433	8.08%
MRSA West	38,387	7.15%	$38,959,884	6.36%
MRSA Central	29,809	5.55%	$33,881,035	5.53%
Travis	26,021	4.85%	$31,602,823	5.16%
Nueces	22,093	4.11%	$27,193,673	4.44%
Jefferson	20,426	3.80%	$21,768,822	3.55%
El Paso	20,458	3.81%	$19,013,808	3.10%
Lubbock	13,835	2.58%	$13,927,277	2.27%

Average STAR Monthly Expenditures by Program and MCO (2016)

MCO Name	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditures
Superior	707,292	23.92%	$132,508,962	23.87%
Amerigroup	573,528	19.40%	$96,007,241	17.29%
Texas Children's	338,822	11.46%	$59,430,258	10.71%
CHC	241,044	8.15%	$52,051,580	9.38%
Parkland	176,495	5.97%	$34,490,171	6.21%
Driscoll Children's	142,700	4.83%	$30,136,939	5.43%
United	121,658	4.12%	$27,851,824	5.02%
Community First	110,178	3.73%	$20,499,832	3.69%
Molina	101,222	3.42%	$18,974,591	3.42%
FirstCare	96,043	3.25%	$18,889,578	3.40%
Cook Children's	100,679	3.41%	$18,559,096	3.34%
Aetna	73,852	2.50%	$14,225,707	2.56%
El Paso First	67,374	2.28%	$11,279,268	2.03%
Scott & White	43,762	1.48%	$8,043,086	1.45%
BCBS	25,102	0.85%	$5,516,706	0.99%
Seton	17,737	0.60%	$2,988,386	0.54%
Sendero	12,637	0.43%	$2,310,954	0.42%
Christus	6,229	0.21%	$1,384,845	0.25%

Average STAR+PLUS Monthly Expenditures by Program and MCO (2016)

MCO Name	Monthly Average Number of Eligible Clients	% of Total - Monthly Average Number of Eligible Clients	Monthly Average Expenditure	% of Total - Monthly Average Expenditures
Superior	144,632	26.94%	$167,564,176	27.35%
Amerigroup	137,294	25.57%	$143,898,495	23.49%
United	114,657	21.36%	$138,714,856	22.64%
Molina	89,482	16.67%	$101,636,731	16.59%
Cigna-HealthSpring	50,839	9.47%	$60,763,888	9.92%

Average Dental Monthly Expenditures by MCO (2016)

MCO Name	Monthly Average Number of Util Clients	Monthly Average Expenditure	% of Total Monthly Average Expenditures
DentaQuest	190,501	$51,319,342	57.27%
MCNA	141,192	$38,285,014	42.73%

D. GEOACCESS

This subsection includes quarterly HHSC network adequacy analysis and geo-mapping for all programs and providers in accordance with STC 41(a). The data sources HHSC uses to complete the analysis and geo-mapping are from the provider files except for pharmacy providers, which are based on MCO self-report. The MCOs are required, by contract, to provide access to at least 90% of its members in each program and service area, for each provider type, within the prescribed distance or travel time standard for each quarter with the exception of pharmacy providers. Attachment E provides distance and travel time benchmarks per county designation for each provider type. Pharmacy provider bench marks are outlined below.

As described in previous reports, travel time and distance geo-access data will be presented in Attachment H with respect to the metro, micro, and rural county designations by provider type. MCO and SDA level data is monitored by HHSC, but due to the amount of raw data, information will be provided in the narrative below for those below the 90% benchmark at the MCO and county designation level with the exception of PCP data which is provided at the MCO and SDA level. Attachment J, Pharmacy GeoMapping, data is provided with respect to program and SDA. As HHSC continues to implement the new process, we continue to work closely with MCOs to ensure that provider files are complete. Additionally, CAPs were issued for all MCOs in the STAR and

STAR Kids program that did not meet at least 75% access for their members in 2017 SFQ4.

The requirements for provider types vary by program and population as described below.

- All STAR, STAR Kids and STAR+PLUS members: PCPs, cardiovascular disease specialist, general surgeon, obstetrician/gynecologist for female members, ophthalmologist, orthopedist, psychiatrist, outpatient behavioral health services, acute care hospitals and pharmacy;
- Children in STAR, STAR Kids, and STAR+PLUS: otolaryngologist (ENT);
- Adults in STAR+PLUS: urologist;
- Dental members: main dentists, pediatric dentist, endodontist, oral surgeons, orthodontist; periodontist and prosthodontist.

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

1. Access to PCPs and Specialty Providers

2017 SFQ4 (June - August)

Geoaccess for the following provider types is reported in Attachment H1 (by program and county designation): cardiovascular, ENT, hospital acute care, nursing facility, OBGYN, prenatal care, psychiatrist, and therapy (OT, PT, ST).

The following plans did not meet the 90% access standard (by provider, program, county designation and MCO):

Cardiovascular

- STAR: Micro-Driscoll, Molina, Seton, and United; Rural-El Paso First and First Care, and Texas Children's
- STAR+PLUS: Micro-Molina; Rural-Amerigroup
- STAR KIDS: Micro-BCBS, Driscoll, and Superior; Rural-Amerigroup

ENT

- STAR: Metro- FirstCare; Micro- Driscoll, Molina, and United; Rural-FirstCare
- STAR Kids: Micro- Driscoll; Rural- Amerigroup and BCBS
- STAR+PLUS: Micro- Molina; Rural- Amerigroup

Hospital- Acute Care

- STAR: Metro-Driscoll, FirstCare, and Molina; Mirco- Driscoll, Molina, and Firstcare; Rural-Aetna, Amerigroup, Christus, Community Health Choice, Driscoll, El Paso First, FirstCare, Molina, Sendero, Seton and United
- STAR Kids: Metro: CMC; Rural: Amerigroup and CMC
- STAR+PLUS: Micro- Molina; Rural- Amerigroup and Molina,

Nursing Facility

- STAR+PLUS: Metro, Micro, and Rural-Cigna

OBGYN

- STAR: Metro/Micro/Rural-FirstCare
- STAR Kids: Micro-Driscoll
- STAR Plus: Metro/Micro/Rural-Cigna

Prenatal Care

- STAR: Metro/Micro- FirstCare; Rural- El Paso First, FirstCare, and Molina
- STAR Kids: Metro- Children's Medical Center; Micro- Driscoll and Texas Children's;
- STAR Plus: Micro-Molina; Rural-Cigna and Molina

Psychiatrist

- STAR: Metro/Micro-FirstCare and Molina; Rural- El Paso First, Molina, FirstCare and Superior
- STAR Kids: Micro-BCBS, Superior, and Texas Children's; Rural- Amerigroup and Superior
- STAR Plus: Micro- Molina and Superior; Rural- Amerigroup, Molina and Superior

Therapy OT PT ST

- STAR: Metro/Micro/Rural- FirstCare

2018 SFQ1 (September - November)

All STAR Kids plans, across all SDAs, met the benchmark for PCP access as shown in Attachment H2. The following plans did not meet the 90% access standard for two PCPs:

STAR

- El Paso First- El Paso SDA
- Molina- Hidalgo SDA
- Superior- El Paso and Hidalgo SDA

STAR+PLUS

- Cigna- Hidalgo SDA
- Molina- Hidalgo SDA

Geoaccess for the following provider types is reported in Attachment H3 (by program and county designation): behavioral health, general surgeon, Opthamologist, orthopedist, pediatric subspecialties, and urologists.

The following plans did not meet the 90% benchmark for the below Medicaid specialties (by provider, program, county designation and MCO):

Behavioral Health-Outpatient

- STAR: Metro/Micro/Rural-FirstCare

General Surgeon

- STAR: Micro- Driscoll and FirstCare; Rural- El Paso First
- STAR Kids: Micro- Driscoll

Opthamologist

- STAR: Micro-Cook, Driscoll, and United; Rural- Amerigroup, El Paso First, and FirstCare
- STAR Kids: Metro- BCBS, CMC, and Cook; Micro- Cook, Driscoll, Texas Children's and United; Rural- Amerigroup and Superior
- STAR Plus: Rural- Amerigroup

Orthopedist

- STAR: Micro- Driscoll, Molina, Superior, and United; Rural- El Paso First and FirstCare
- STAR Kids: Micro- Superior and Texas Children's
- STAR Plus: Micro- Cigna, Molina, and Superior

Pediatric Subspecialties

- STAR: Micro- Seton, Superior and United; Rural-FirstCare
- STAR Kids: Micro- Superior, Texas Children's and United

Urologist

- STAR: Metro-Driscoll and FirstCare; Micro: Driscoll, Molina, Superior, Texas Children's and United; Rural- Driscoll, El Paso, FirstCare, Sendero, Superior, Texas Children's and United
- STAR Kids: Metro- Driscoll, Superior and Texas Children's; Micro- Cook, Driscoll, Superior, Texas Children's and United; Rural- Amerigroup, Driscoll, Superior, Texas Children's and United
- STAR Plus: Micro- Molina and Superior; Rural- Amerigroup, Cigna, Superior, and United

2. Access to Pharmacy

Attachment J provides summaries of MCO self-reported geo-mapping data by plan and SDA for pharmacies. For all STAR, STAR Kids and STAR+PLUS SDAs, the following benchmarks applied:

- 75% – access to a network pharmacy in urban counties within 2 miles
- 55% – 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 2017 SFQ4 and 2018 SFQ1. Several programs complied with the standard for urban county residents to be within 2 miles of a pharmacy in the STAR MRSA. There were only six exceptions to compliance in 2017 SFQ4 and seven in 2018 SFQ1. Fewer programs complied with the standard for members in suburban counties residing within 5 miles of one pharmacy in STAR+PLUS and non-MRSA STAR as there were several exceptions to compliance. 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.

3. Dental Geo-mapping

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

- 95% –main dentist in metro areas within 30 miles;
- 95% –main dentist in micro areas within 30 miles; and
- 95% –main dentist in rural areas within 75 miles.

2017 SFQ4 (June - August)

Access to dental specialty providers (periodontists, oral surgeons, endodontists and prosthodontists) is limited in some parts of Texas as depicted in Attachment H4. Additionally, HHSC continues to work with the DMOs to ensure provider files are complete. 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.

2018 SFQ1 (September - November)

In 2018 SFQ1, both DentaQuest and MCNA maintained sufficient provider networks for main dentists in all areas as shown in Attachment H5.

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 41(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.[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.

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

[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.

reasonably requested documentation.

- Pharmacy

According to the managed care contracts, MCOs must guarantee access to at least one 24-hour pharmacy within 75 miles. Attachment J provides pharmacy GeoMapping for all MCOs by program and service delivery area.

- 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.

- 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 survey providers 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 8.39% 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, trainings) and unscheduled calls to providers to reassess compliance. MCOs employ contractual remedies for the provider until compliance is achieved or the provider contract is terminated.

- External Quality Review Organization (EQRO) Member Satisfaction Surveys

Currently, the most recent EQRO member satisfaction surveys are complete and results will be submitted to CMS as part of the annual summary of activities report.

F. 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.

2017 SFQ4 (June - August)

Attachment D details the OON utilization rates by program, MCO and SDA. The following plans listed below exceeded OON utilization standards in 2017 SFQ4. The State will continue to monitor these plans and will require corrective action or other remedies if appropriate.

STAR

- Aetna: Bexar and Tarrant SDAs
- Amerigroup: Harris, and MRSA Central SDAs
- Christus: Nueces SDA
- First Care: MRSA West SDA
- Molina: Dallas and Jefferson SDAs
- Seton: Travis SDA
- Texas Children's: Harris SDA

STAR+PLUS

- Amerigroup: Harris and Tarrant SDAs
- Cigna Health-Spring: Tarrant and Hidalgo SDAs
- Molina: Dallas SDA
- Superior: Dallas and MRSA West SDAs
- United: Harris and MRSA Central SDAs

STAR Kids

- Amerigroup: Dallas, El Paso, and Harris SDAs
- Children's Medical Center: Dallas SDA
- Texas Children's: Harris, Jefferson, and MRSA Northeast SDAs

[2] Texas Government Code §533.005(a)(11).

[3] 1 Texas Administrative Code §353.4(e)(2).

- United: MRSA Central SDA

HHSC has recommended LDs for Christus (Nueces SDA) and approved special exception requests for the following MCOs/SDAs:

- Aetna (STAR-Bexar and Tarrant SDAs)
- Amerigroup (STAR-Harris and MRSA Central SDAs and STAR+PLUS-Tarrant and Harris SDAs)
- First Care (STAR-MRSA West SDA)
- Texas Children's (STAR-Harris SDA)
- Molina (STAR-Dallas and Jefferson SDA and STAR+PLUS-Dallas SDA)
- Superior (STAR+PLUS-Dallas and MRSA West SDAs)
- Cigna (STAR+PLUS-Hidalgo and Tarrant SDAs)
- United (STAR+PLUS-Harris and MRSA Central SDAs)

The State will continue to monitor these plans and will require corrective action or other remedies if appropriate. All STAR Kids MCOS are exempt from OON performance standards due to continuity of care contract provisions. This exemption will be through 2018 SFQ2 allowing for claims lag. 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 2017 SFQ4. In the Dental Program, the 20% standard for "other services" applies to out-of-network dental services.

2018 SFQ1 (September - November)

The following plans listed below exceeded OON utilization standards in 2018 SFQ1. The State will continue to monitor these plans and will require corrective action or other remedies if appropriate.

STAR

- Aetna: Bexar and Tarrant SDAs
- Amerigroup: Harris, and MRSA Central SDAs
- Christus: Nueces SDA
- Molina: Dallas and Jefferson SDAs
- Seton: Travis SDA
- Texas Children's: Harris SDA

STAR+PLUS

- Amerigroup: Harris SDA
- Cigna Health-Spring: Tarrant and Hidalgo SDA

- Molina: Dallas and Harris SDAs
- Superior: Dallas SDA
- United: Harris and Jefferson SDAs

STAR Kids

- Amerigroup: Lubbock and Harris SDAs
- Children's Medical Center: Dallas SDA
- Driscoll: Hidalgo SDA
- Superior: MRSA West SDA
- Texas Children's: Harris and MRSA Northeast SDAs
- United: Jefferson and MRSA Central SDAs

HHSC approved special exception requests for the following MCOs:

- Aetna (STAR-Bexar and Tarrant SDAs)
- Texas Children's (STAR-Harris SDA)
- Seton (STAR Travis SDA)
- Molina (STAR-Dallas and Jefferson SDAs and STAR+PLUS-Dallas SDA)
- Cigna (STAR+PLUS-Hidalgo and Tarrant SDAs)
- Superior (STAR+PLUS-Dallas SDA)

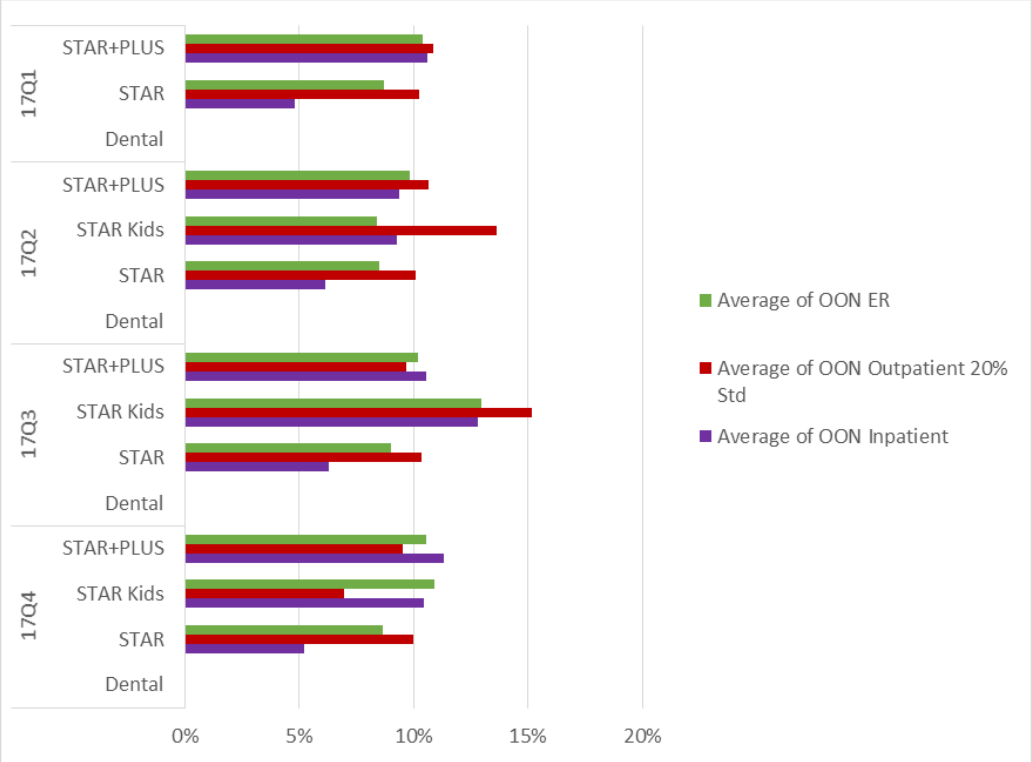
The State will continue to monitor these plans and will require corrective action or other remedies if appropriate.

All STAR Kids MCOS are exempt from OON performance standards due to continuity of care contract provisions. This exemption will be through 2018 SFQ2 allowing for claims lag. 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 2018 SFQ1. In the Dental Program, the 20% standard for "other services" applies to out-of-network dental services.

2017 SFQ1 through SFQ4

Analysis of the 2017 OON data revealed, among STAR MCOs/SDAs, the average ER OON (-0.35%), inpatient (-1.07%) and outpatient (-0.37%) OON utilization rates decreased marginally from SFQ3 to SFQ4. In the STAR+PLUS program, the average ER (.36%) and inpatient (0.77%) increased while the outpatient OON (-0.14%) usage decreased from SFQ3 to SFQ4. In the STAR Kids program, the average ER (-2.03%), inpatient (-2.33%), and outpatient (-8.21) decreased from SFQ3 to SFQ4.The graph below includes the average ER, outpatient and inpatient utilization rates among the STAR, STAR Kids, and STAR+PLUS programs. The table below identifies, during SFY2017, the average outpatient OON was the largest in all four quarters for all programs except for STAR Kids in 2017Q4.



- Special Exception Request Process

Special Exception Requests (SERT) may be granted for MCOs that do not meet one or more of the Out-of-Network utilization standards. If an MCO does not meet one or more of the standards when submitting their quarterly deliverable(s), the MCO may submit a SERT. If approved, the MCO must submit the special calculation report within five business days of the SERT approval. The special calculation reports should exclude each provider(s) for which the SERT was approved.

IV. OUTREACH/INNOVATIVE ACTIVITIES TO ASSURE ACCESS

This section addresses the quarterly requirements for STC 71 regarding outreach and other initiatives to ensure access to care. The Dental Stakeholder Update addresses STC 42(c) and the Medicaid Managed Care Advisory Committee meeting update also addresses STC 71.

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 2017 D6Q4 Demonstration period (July-September 2017) MAXIMUS sent 290,080 enrollment mailings to potential STAR, STAR Kids, and STAR+PLUS clients, and 199,249 mailings to potential Dental Program clients. MAXIMUS field staff completed 30,276 home visit attempts for these programs and 234,372 phone call attempts. Additionally, MAXIMUS completed 5,723 field events, which included enrollment events, community contacts, presentations, and health fairs.

During the 2018 D7Q1 Demonstration period (October - December 2017) MAXIMUS sent 267,667 enrollment mailings to potential STAR, STAR Kids, and STAR+PLUS clients, and 187,689 mailings to potential Dental Program clients. MAXIMUS field staff completed 23,874 home visit attempts for these programs and 127,784 phone call attempts. Additionally, MAXIMUS completed 6,485 field events, which included enrollment events, community contacts, presentations, and health fairs.

The full report for both 2017 D6Q4 and 2018 D7Q1 are 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 October 13, 2017, 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.

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.

Committee meetings were held on August 17, 2017, and November 9, 2017. At the August 2017 meeting, the SMMC discussed the committee's annual report to the Executive Commissioner and established a subcommittee to work on the report. The committee also discussed suggested changes and feedback to the SMMC Strategic Plan. HHSC will make the revised strategic plan with comments available prior to the next strategic plan subcommittee.

At the November 9, 2017 meeting, the committee received an update on state and federal legislative actions that have impacted Medicaid managed care, specifically: mental health screening, behavioral health, ensuring continued coverage, pharmacy benefits, telemedicine, and budget rider requirements. An update on the September 1, 2017 Medicaid managed care carve-in for recipients of Adoption Assistance, Permanency Care Assistance, and Medicaid for Breast and Cervical Cancer programs was also provided. The SMMC discussed the agency's operational plan and Medicaid organizational chart. Additionally, the SMMC discussed and adopted changes to the committee's strategic plan and the committee's report to the Executive Commissioner.

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.

DY6 Q4 July - September 2017

The Medical Care Advisory Committee (MCAC) met on August 24th, 2017. 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, provided information and updates regarding the Network Access Improvement Program (NAIP), 1115 waiver renewal negotiations and Special Legislative Session. Also on the agenda was a discussion regarding the DSRIP Program Demonstration Years 7-8, including reporting categories A-D. Members of the MCAC provided comments and questions related to renewal discussions (UC and DSRIP), DSRIP DY 7-8 reporting, DSRIP future, and had questions regarding opportunities for new DSRIP projects. No members of the public provided comment during the meeting.

DY7 Q1 October - December 2017

The Medical Care Advisory Committee (MCAC) met on November 16, 2017. The date, time and location of the MCAC were published on the HHSC website prior to the meeting. During the meeting, HHSC explained 1115 waiver renewal negotiations were ongoing and as soon as negotiations conclude, an update on the renewal would be provided. MCAC members provided input regarding concerns about the renewal from a provider's perspective. 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.

DY6 Q4 July - September 2017

1. Office of the Ombudsman

Compared to the third quarter of 2017, the Ombudsman Managed Care Assistance Team (OMCAT) abandoned 24% additional calls averaging a call abandonment rate of 8% as compared to 6% calls abandoned in the previous quarter. The increase in calls abandoned is due to a procedural change intended to route more Spanish calls to bilingual staff; however this decreased the availability of staff for the English calls which are the majority of calls received. The decrease is also due to allowing staff more time off the phones to handle open assignments that could not be resolved on the first call. The office received a 67% increase in complaints in the fourth quarter as compared to the third. The increase in complaints can be attributed to: billing issues, MCOs not showing members as active in their systems when clients are trying to access prescriptions, and issues with eligibility and or recertification for Medicaid. The OMCAT unit continued to direct a managed care support network to better coordinate assistance provided to Medicaid managed care clients as mandated by 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 and now meets quarterly. The network facilitated a meeting on June 22, 2017 for the fourth quarter.

2. Aging and Disability Resource Center (ADRC)

Local-level ADRC staff continue to participate in training activities about resources and referral protocols. Training this quarter included sessions on respite care programs to assist ADRCs in developing and implementing local programming to meet the needs of their communities. ADRCs also received training on fiscal management resources, nursing home placement, consumer-directed services, mental wellness for older adults, and the STAR Kids and Kincare program. Additionally, training was provided on strategies to engage community partners to expand supportive housing opportunities.

The dates and topics were as follows:

- July 17: Texas Health and Human Services – ADRC Respite Care Programs
- July 18: Texas Health and Human Services – Fiscal Management Resources
- July 26: Nursing Home Placement Process
- August 15: Consumer Directed Services
- August 22: Mental Health Parity and Mental Wellness for Older Adults
- August 24: Disordered Gambling Conference
- August 30: Engaging Community Partners to Expand Supportive Housing
- September 12: STAR Kids and Kincare
- September 26: ADRC Fiscal Management – Travel Policies and Budgeting

On July 17, 2017, the ADRC Advisory Committee convened and committee members received in-depth information on the types of respite care programs implemented by four ADRCs over the past three years. The ADRC presentations addressed targeted populations, as well as program partners, types of services provided, challenges and successes encountered, and case studies.

DY7 Q1 October - December 2017

1. Office of the Ombudsman

Compared to the fourth quarter for FY17, the Ombudsman Managed Care Assistance Team (OMCAT) received an increase in complaints in the following programs:

- Superior STAR Plus in the Hidalgo service area regarding access to DME and access to prescriptions;
- Texas Children's Health Plan STAR in the Harris service area related to access to prescriptions;
- United Health Care STAR Plus in the Harris service area related to access to long term services and supports and access to in-network specialty care.

Some of the increase in complaints is attributable to the expansion of Adoption Assistance and Medicaid for Breast and Cervical Cancer that was transitioned into managed care during the first quarter of FY18.

The OMCAT unit continued to direct a managed care support network to better coordinate assistance provided to Medicaid managed clients as mandated by 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 and now meets quarterly. The network facilitated a meeting on September 14, 2017 for the first quarter of FY18.

2. Aging and Disability Resource Center (ADRC)

During the period of October through December 2017, ADRC staff continued to participate in training activities about core services, resources, and referral protocols. Training this quarter included a 1.5-day training conference for ADRC Housing Navigators, during which presentations were made by the Texas Department of Housing and Community Affairs ("Programs Overview"); the San Antonio Regional Housing and Urban Development Office ("Working with Housing and Urban Development in your Community"); and the Corporation for Supportive Housing ("Expanding Quality Supportive Housing 101" and "Effective Developer and Landlord Engagement"). Participants also attended an on-site session at an apartment complex to learn more about the "Tax Developer's Perspective."

Additionally, ADRCs received training on working with nursing facilities regarding Local Contact Agency referrals, as well as understanding the Legislative Budget Board (LBB) performance measures for which they must submit quarterly reports.

The dates and topics were as follows:

- November 8-9: Texas Health and Human Services – Housing Navigator Conference
- November 30: Section Q and the Local Contact Agency: What Nursing Facilities Need to Know
- December 5: ADRC LBB Measures

On October 16, 2017, the ADRC Advisory Committee convened and committee members and representatives from the 22 ADRCs received in-depth information on strategies for launching faith-based and volunteer respite programs at the local level.

F. HHSC MANAGED CARE INITIATIVES

Rider 175

Senate Bill 1, General Appropriations Act, 2017, 85th Regular Session, Texas Legislature, Article II, Health and Human Services Commission (HHSC), Rider 175 requires HHSC to develop performance metrics to better hold managed care organizations (MCOs) accountable for care of enrollees with serious mental illness (SMI). HHSC must submit a report to the Legislative Budget Board (LBB) and Office of the Governor by November 1, 2018, on the performance measure implementation. HHSC may also, if cost effective, develop and procure a managed care program for an alternative model by which to treat persons with SMI in Medicaid and CHIP in at least one service delivery area of the state. As part of its analysis, HHSC will post a request for information (RFI) seeking input from stakeholders regarding managed care services for persons with SMI. Specifically, HHSC is seeking:

- Information on best practices, including addressing gaps for serving individuals with SMI or SED;
- Recommendations on how to best monitor for quality and program outcomes; and
- Input from the public to inform HHSC on assumptions related to an integrated pilot program.

Integration

Through the implementation of SB 58, 83rd Texas Legislature, Regulation Session, SB 200, 84th Legislature, Regular Session, and SB 74, 85th Legislature, Regular Session, HHSC has been working toward integrating physical and behavioral health care at the health plan level. SB 58, 83R required HHSC to carve mental health targeted case management and mental health rehabilitative services (MH TCM/Rehab) into managed care, and also required the state to pursue two health home pilots for people with co-occurring serious mental illness and at least one chronic condition. HHSC has carved MH TCM/Rehab into managed care and is currently updating the

Texas Administrative Code to be inclusive of private providers who did not deliver MH TCM/Rehab under the fee-for-service system. HHSC is also evaluating two health home pilot sites that have integrated primary care into a mental health care setting.

SB 200, 84R, required HHSC to monitor physical and behavioral health integration among Medicaid and CHIP managed care organizations (MCOs). HHSC has taken three tracks to comply with this requirement. First, identified additional monitoring mechanisms for targeted managed care contract provisions that have a focus on integrating physical and behavioral health. Second, the state identified existing integration-related quality measures, identifying four measures to review for trends. These measures have not been collected long enough to gauge patterns. The state also worked with our External Quality Review Organization (EQRO) to conduct an analysis of potentially preventable events among members with co-occurring behavioral health and physical health conditions. Third, the state developed and disseminated a survey to MCOs to measure their current level of integration in five categories: MCO organizational characteristics, multi-disciplinary health care approach, interdisciplinary communication, care coordination, and continuous quality improvement. The state is in the process of analyzing these results.

SB 74, 85R, requires that MCOs that subcontract their behavioral health services and delivery to a behavioral health organization do several things: effectively share and integrate care coordination, service authorization, and utilization management data, encourage co-location of physical and behavioral health care coordination staff, require warm call transfers between physical and behavioral health care coordination staff, implement joint rounds or another effective means of sharing clinical information for physical and behavioral health services network providers, and ensure that physical and behavioral health provider portals are linked seamlessly to the extent allowed by federal law. HHSC is currently adding these provisions to MCO contracts, and will require these provisions of all MCOs, regardless of whether or not they subcontract with a behavioral health organization.

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 2017 SFQ4 and 2018 SFQ Q1. 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 71, regarding operational issues identified during 2017 DY6Q4 and 2017 DY6Q5. 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. HHSC filed Appellant's brief on January 18, 2017. Legacy filed Appellee's brief on March 29, 2017.

On January 31, 2018, the U.S. 5th Circuit Court of Appeals reversed the trial court's decision and ruled in favor of HHSC on all claims. Specifically, the appellate court ruled: (1) the Commission's requirement that MCOs fully reimburse FQHCs does not violate the Medicaid Act; (2) Legacy lacks standing to challenge the Commission's lack of a policy that the state directly reimburse an FQHC if it is not fully reimbursed by the MCO; and (3) Legacy is not entitled to reimbursement for the non-emergency, out-of-network services about which it complains.

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. The plaintiffs and CMS filed motions for summary judgment which remain pending before the court.

On April 24, 2017, CMS notified the court that CMS published a final rule amending the text of 42 C.F.R. § 447.299(c)(10), the regulation whose interpretation is at issue in the lawsuit, to clearly state that "Total Cost of Care for Medicaid IP/OP Services" is to be the computed net of third-party payments, including Medicare and private insurance payments. The amended rule became effective June 2, 2017.

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, issued its mandate, and remanded the above-discussed portions of the case to the district court for further proceedings in accordance with its opinion.

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.

XW and KRW by their next friend, AW, and BA by his next friend, CB v. Smith and Snyder (official capacities). On December 6, 2016, three Plaintiffs (XW, KRW, and BA) filed Civil Action No. 5:16-cv-1235 in the U.S. District Court, Western District of Texas, San Antonio Division against HHSC's Executive Commissioner and State Medicaid Director. The suit alleges that the Plaintiffs have been diagnosed with Autism Spectrum Disorder and that the state officials are in violation of 42 U.S.C. § 1983 because they have denied the Plaintiffs Applied Behavior Analysis (ABA) as a Medicaid benefit under EPDST. Plaintiffs maintain the following claims: (1) Defendants violated, and continue to violate, Plaintiffs' right to receive ABA as an EPSDT benefit through the Medicaid program, in violation of 42 U.S.C. §§ 1396a(a)(43) and 1396d(r)(5); (2) Defendants violate Plaintiffs' right to have "available" ABA, in violation of 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(43), and 1396d(r)(5); and (3) Defendants violate Plaintiffs' right to information about ABA as a Medicaid benefit, in violation of 42 U.S.C. § 1396a(a)(43)(A). In January 2018, after settling the lawsuit, the parties filed a joint stipulation of dismissal of the lawsuit.

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 41(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 - V4 are summaries of the health and dental plans' 2017 SFQ3 through SFQ4 claims adjudication results. For these quarters, STAR, STAR Kids and STAR+PLUS MCOs reported results for acute care, behavioral health, vision services, and pharmacy claims. Additionally, STAR+PLUS and STAR Kids 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 2017 SFQ3 and SFQ4. HHSC staff is in the process of developing an appropriate remedy for the MCOs that are not in compliance with the claims adjudication standards. The MCOs that are not in compliance with the claims adjudication standards are listed below.

STAR

Acute Care Claims

- Cook: Tarrant SDA
- Seton: Travis SDA
- Community 1st: Bexar
- Driscoll: Hidalgo and Nueces SDAs

- Sendero: Travis SDA

Behavioral Health Services Organization's Claims

- Amerigroup: Bexar, Jefferson, and MRSA West SDAs
- Christus: Nueces SDA
- Cook: Tarrant SDA
- Community 1st: Bexar SDA
- Driscoll: Hidalgo and Nueces SDAs
- First Care: Lubbock SDA
- Seton: Travis SDA
- Texas Children's: Harris and Jefferson SDAs

Vision Services Organization's Claims

- Amerigroup: Bexar, Harris, Jefferson, Lubbock, MRSA Central, Tarrant, MRSA Northeast and MRSA West SDAs
- Seton: Travis SDA
- Christus: Nueces SDA
- United: Harris, Hidalgo, and Jefferson SDAs

STAR+PLUS

Acute Care Claims

- Amerigroup: Bexar, Jefferson, and Lubbock SDAs
- Cigna-Heath Spring: MRSA Northeast SDAs
- Molina: Bexar, Dallas, El Paso, Harris, Hidalgo and Jefferson SDAs
- Superior: MRSA West SDA
- United: Harris and MRSA Central SDAs

Behavioral Health Services Organizations Claims

- Cigna-Health Spring: Hidalgo SDA
- United: MRSA Central and Travis SDA
- Molina: El Paso and Jefferson SDA

Vision Services Claims

- Amerigroup: Bexar, Harris, Jefferson, Lubbock, MRSA West, Tarrant, and Travis SDAs
- Molina: Dallas SDA
- United: Harris, Jefferson, MRSA Central, MRSA Northeast, Travis and Nueces SDAs

Long Term Care Organization's Claims

- Amerigroup: Lubbock and MRSA West SDAs
- Molina: Dallas, El Paso, Hidalgo, Jefferson and Harris SDAs
- United: MRSA Central, Jefferson, and Travis SDAs

STAR Kids

Acute Claims

- Aetna: Tarrant SDA
- BCBS: MRSA Central and Travis SDAs
- CMC: Dallas SDA
- Community 1st: Bexar SDA
- Cook Children's: Tarrant SDA
- Driscoll: Hidalgo and Nueces SDA
- Superior: Bexar, Lubbock, and MRSA West SDAs
- Texas Children's: Harris, Jefferson, and MRSA Northeast SDAs
- United: MRSA Central SDA

Behavioral Health Claims

- Community 1st: Bexar SDA
- Driscoll: Nueces and Hidalgo SDAs
- Texas Children's: Harris, Jefferson, and MRSA Northeast SDAs

Vision Claims

- Amerigroup: Dallas, Harris, and Lubbock SDAs
- United: Hidalgo, Jefferson, MRSA Central and MRSA Northeast SDAs

Long Term Care Organization's Claims

- Aetna: Tarrant SDA
- Amerigroup: MRSA West SDA
- BCBS: Travis SDA
- Community 1st: Bexar SDA
- Cook Children's: Tarrant SDA
- Driscoll: Hidalgo and Nueces SDA
- Superior: Bexar, El Paso, Hidalgo, Lubbock, MRSA West, Nueces, and Travis SDAs
- Texas Children's: Harris, Jefferson, and MRSA Northeast SDAs
- United: Harris, Jefferson, and MRSA Northeast 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 Kids, STAR+PLUS, and Dental Program plans sent to the OIG for FY 2017.

In SFQ3 and SFQ4, MCOs forwarded 87 suspected cases of fraud, waste, or abuse to the OIG. Most of these referrals related to non-appropriate billing and program non-compliance. OIG returned 7 of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for 27 cases. Dental plans forwarded eight suspected cases of fraud, waste, or abuse to the OIG. All of these referrals were related to non-appropriate billing. OIG returned two of the cases to the MCO for the determination of appropriate action and launched a full scale investigation for four cases.

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 71.

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 2017 D6.

VIII. FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES

This section addresses the quarterly reporting requirements in STCs 52, 69 and 71 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 2017 SFQ4 or 2018 SFQ1.

IX. MEMBER MONTH REPORTING

The tables below address the quarterly reporting requirements regarding eligible member month participants in compliance with STC 56.

DY6 Q4 July - September 2017

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Jul 2017)	Month 2 (Aug 2017)	Month 3 (Sept 2017)	Total for Quarter Ending Sept 2017
Adults	288,195	289,184	295,700	873,079
Children	2,588,365	2,591,953	2,661,419	7,841,737
AMR	*356,083*	356,430	356,325	1,068,838
Disabled	419,605	419,344	418,395	1,257,343

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Jul 2017)	Month 2 (Aug 2017)	Month 3 (Sept 2017)	Total for Quarter Ending Sept 2017
Adults in MRSA	-	-	-	-
Foster Care	34,974	35,260	35,402	105,636
Medically Needy	137	133	133	403
CHIP-Funded	273,746	273,071	272,769	819,586
Adoption Subsidy	53,992	54,264	-	108,255
STAR+PLUS 217-Like HCBS	18,755	18,808	18,920	56,482

DY7 Q1 October - December 2017

Eligibility Groups Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Oct 2017)	Month 2 (Nov 2017)	Month 3 (Dec 2017)	Total for Quarter Ending Dec 2017
Adults	291,809	289,105	288,295	869,209
Children	2,668,653	2,679,274	2,685,079	8,033,007
AMR	357,539	357,627	357,652	1,072,818
Disabled	419,498	419,129	419,029	1,257,656

Eligibility Groups Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1 (Oct 2017)	Month 2 (Nov 2017)	Month 3 (Dec 2017)	Total for Quarter Ending Dec 2017
Adults in MRSA	-	-	-	-
Foster Care	35,688	36,016	36,261	107,965
Medically Needy	162	146	146	454
CHIP-Funded	274,135	277,009	278,769	829,913
Adoption Subsidy	-	-	-	-
STAR+PLUS 217-Like HCBS	18,904	18,878	18,865	56,647

X. CONSUMER ISSUES

This section addresses quarterly reporting requirements in STCs 23(l), 24(l), 41(a) and 71 regarding complaints and calls to HHSC Managed Care Compliance and Operations (MCCO), formally Health Plan Management, 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. During review of 2017 SFQ4 and 2018 SFQ1, it was found that STAR Kids data was reported incorrectly. To rectify, for 2018 SFQ1, STAR Kids data has been reported separately.

In 2017 SFQ4, calls to the MCO member hotlines increased by 1.05%. Calls to the MCO provider hotlines decreased by 1.03% and calls to the behavioral health hotline increased by 8.86% in 2017 SFQ4. In the Dental Program for 2017 SFQ4, calls to the member hotlines increased by 6.81% and calls to the provider hotline increased by 9.55%.

In 2018 SFQ1, calls to the MCO member hotlines increased by 2.72%. Calls to the MCO provider hotlines decreased by 3.18% and calls to the behavioral health hotline decreased by 11.98% in 2018 SFQ1. In the Dental Program for 2018 SFQ1, calls to the member hotlines decreased by 12.91% and calls to the provider hotline decreased by 8.90%. STAR Kids MCO member hotlines increased by 2.36% in 2018 SFQ1. Calls to the MCO provider hotline decreased by 2.27% and behavioral health increased by 23.52% in 2018 SFQ1.

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 2017 SFQ4 and remained consistent in 2018 SFQ1.

Member Hotline Calls Received per 1,000 Members (2017 SFQ1 - 2018 SFQ1)

	Member Hotline per 1,000 Members				
	SFY17				SFY18
MCO	**Q1**	**Q2****	**Q3****	**Q4**	**Q1**
Aetna*	523	467	460	490	517
Amerigroup*	240	183	180	184	190
BCBS*	318	293	277	299	290
CHC*	176	178	186	170	172
Christus*	721	741	1,047	1,040	1,059
Cigna-HealthSpring	569	513	491	508	518
Community 1st*	291	308	308	271	233
Cook Children's*	222	246	240	343	305
Dentaquest	72	72	77	82	68
Driscoll*	159	142	139	144	158
El Paso 1st*	152	175	163	168	169
FirstCare*	141	127	112	110	117
MCNA	109	98	99	107	93
Molina*	933	516	514	491	503
Parkland*	246	238	237	244	266
Scott & White	161	151	154	150	156
Sendero*	281	347	318	367	287
Seton*	402	282	220	212	179
Superior*	257	225	231	254	245
Texas Children's*	133	126	125	129	145
United*	700	323	326	376	359
Statewide (excludes dental program)	**275**	**234**	**235**	**245**	**245**

*Enrollment and Hotline data includes CHIP program (excludes STAR Kids)

** Previous numbers were incorrectly reported and have been updated.

Majority of the MCOs and DMOs met the following hotline performance in 2017 SFQ4 and 2018 SFQ1:

- 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.

Member Hotline, Attachment M1

2017 SFQ4 (June - August)

- 100% of the member hotline calls were answered by the 4th ring for all MCOs.
- All MCOs member hotline calls were above the 80% standard for answered by a live person within 30 seconds.
- There were no MCOs that exceeded the ≤7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

2018 SFQ1 (September - November)

- Member hotline calls were answered by the 4th ring for all MCOs.
- MCOs member hotline calls were above the 80% standard for answered by a live person within 30 seconds with the exception of Parkland (79.68%).
    - Parkland explained the hotline was understaffed by six representatives; however, staff hours have been adjusted and other staff brought in to assist during the shortage.
- There were no MCOs that exceeded the ≤7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

Behavior Health Hotline (BH), Attachment M2

2017 SFQ4 (June - August)

- 100% of the BH hotline calls were answered by the 4th ring for all MCOs.
- All MCOs BH hotline calls were above the 80% standard for answered by a live person within 30 seconds with the exception of Texas Children's (76.92%).
    - Texas Children's reported the reason for behavioral health hotlines call hold rate non-compliance was related to increased call volume and difficulty being appropriately staffed during several events, specifically building closure due to water shut off and Hurricane Harvey. The three quarters prior, the MCO was in compliance with all hotline standards.
- All MCOs were below the ≤7% abandoned calls standard.
- 100% of the behavioral health hotline average hold time was under two minutes.

2018 SFQ1 (September - November)

- 100% of the BH hotline calls were answered by the 4th ring for all MCOs.
- All MCOs BH hotline calls were above the 80% standard for answered by a live person within 30 seconds.
- 100% of the behavioral health hotline average hold time was under two minutes.
- Several MCOs were over the ≤7% abandoned calls standard (Aetna, Amerigroup, CHC, Cook,

Parkland, Sendero, Superior, and Texas Children's.

- Aetna indicated that non-compliance occurred due to inadequate coverage during team meetings and late coverage as they were short one staff member during November 2017.
- Sendero, CHC, Cook, and Parkland reported non-compliance occurred due to being closed in observance of Veterans Day and routing of calls during that time. The process has been corrected so the issue will not occur in the future.
- Texas Children's reported they were one call short from meeting the standard and this occurred due to a higher call volume for this quarter
- Amerigroup reported there was an update to the telephone system and due to the update, there were issues that prevented some agents from logging in timely and errors when routing calls leading to the non-compliance.
- Superior explained that non-compliance was due to staff turnover and to address the issue they have implemented several changes (e.g. adjust breaks, offer overtime, have supervisors and team leads answer phones during peak times).

Provider Hotline, Attachment M3

2017 SFQ4 (June - August)

- 100% of the provider hotline calls were answered by the 4th ring for all MCOs.
- There were no MCOs that exceeded the ≤7% abandoned calls standard.
- All MCOS average hold times were under two minutes.

2018 SFQ1 (September - November)

- Provider hotline calls were answered by the 4th ring for all MCOs.
- Only Superior exceeded the ≤7% abandoned calls standard.
  - Superior explained that non-compliance was due to staff turnover and to address the issue they have implemented several changes (e.g. adjust breaks, offer overtime, have supervisors and team leads answer phones during peak times).
- All MCOS average hold times were under two minutes.

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. 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.

STAR

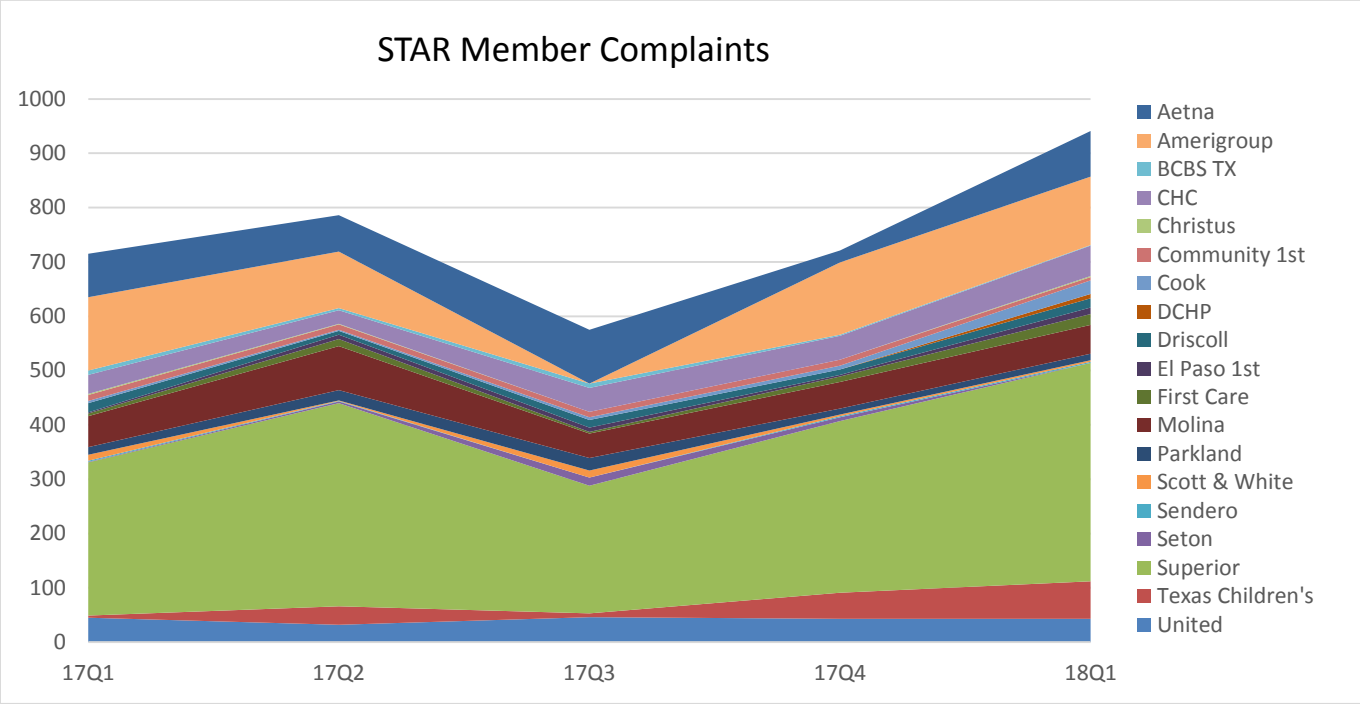
2017 SFQ4 (June - August)

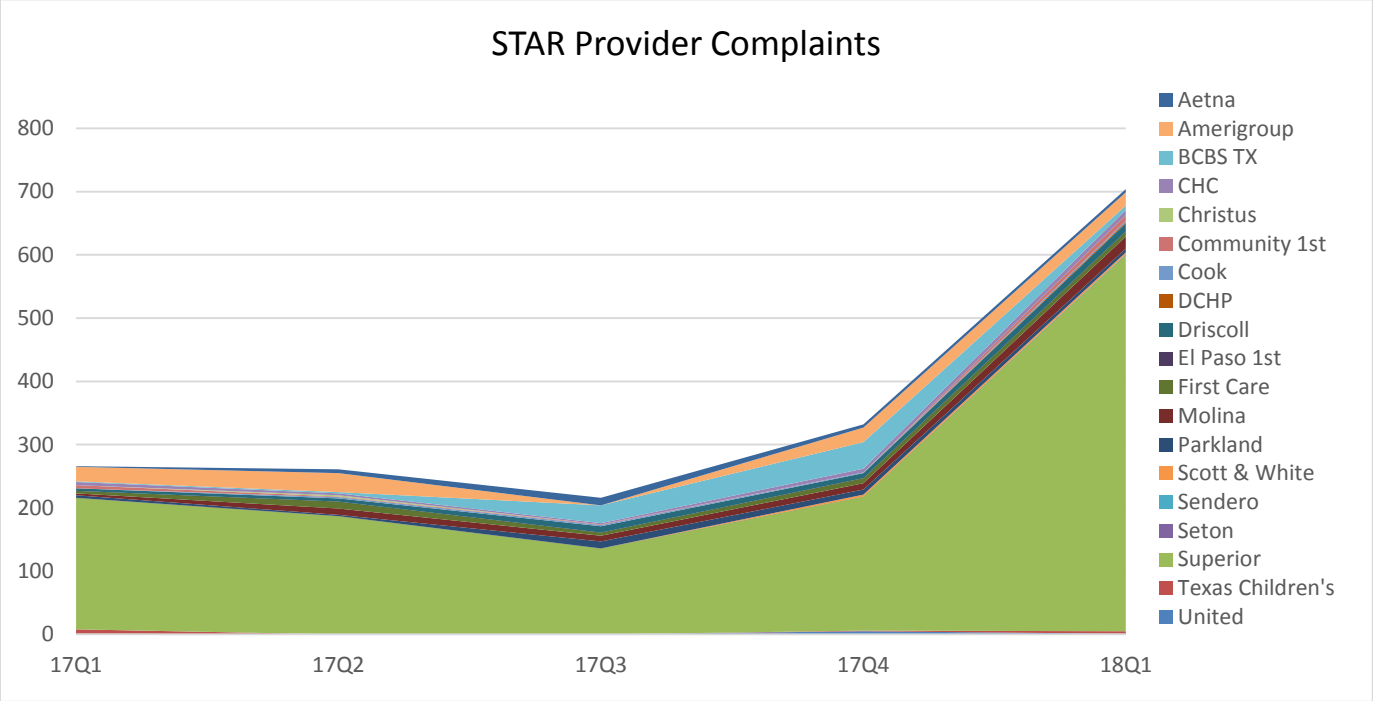
The total number of STAR complaints and appeals received by plans increased from 1,799 in 2017 SFQ3 to 2,480 in 2017 SFQ4, as shown in the following figures below. STAR plans collectively reported 721 member complaints, 1,427 member appeals and 332 provider complaints in 2017 SFQ4.

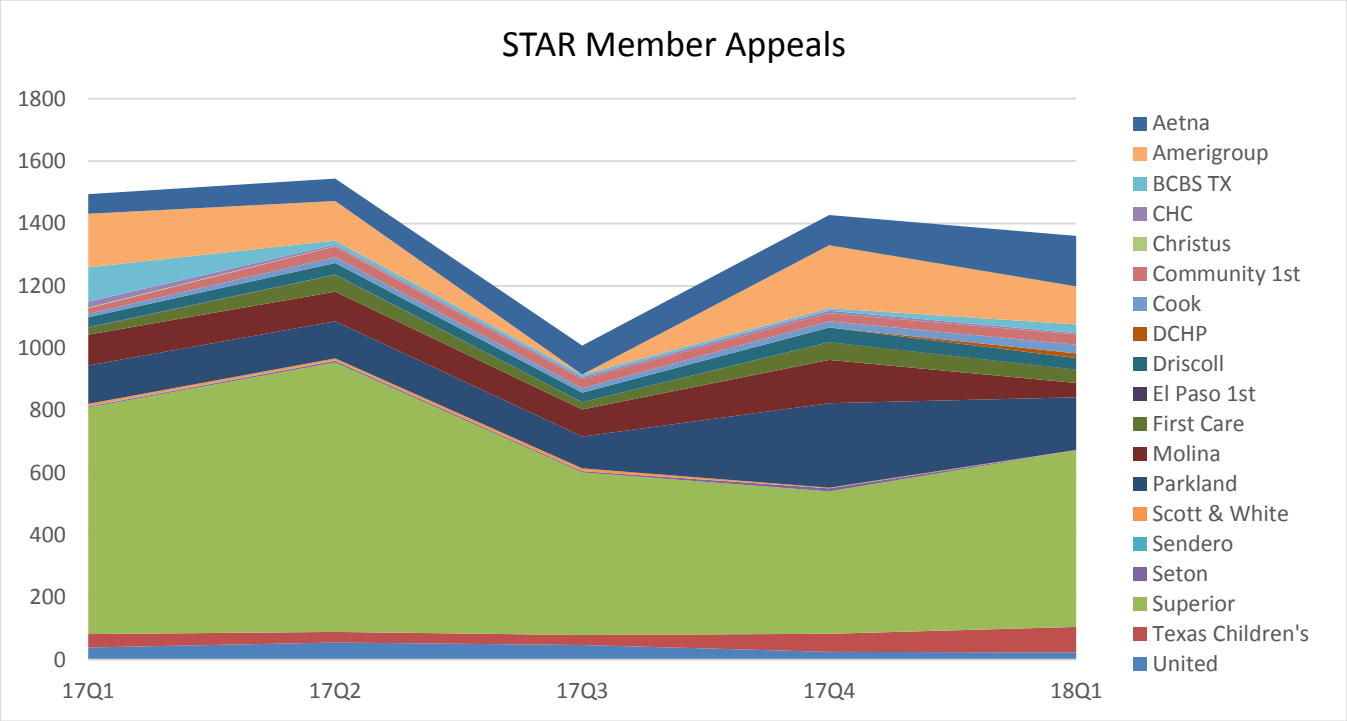
2018 SFQ1 (September - November)

The total number of STAR complaints and appeals received by plans increased from 2,480 in 2017 SFQ4 to 3,005 in 2018 SFQ1, as shown in the following figures below. STAR plans collectively reported 941 member complaints, 1,360 member appeals and 704 provider complaints in 2018 SFQ1.

Complaints and Appeals Received by STAR MCOs (2017 SFQ1 – 2018 SFQ1)







2017 SFQ4 (June - August)

Member Complaints

- Several STAR MCOs did not meet the benchmark for the timely resolution of member complaints including BCBS (Travis SDA), First CARE (Lubbock SDA), Molina (Dallas SDA), and Texas Children's (Harris SDA).

- Texas Children's explained there was a staffing change in the complaints role, which caused cases to be addressed outside of the 30 day standard. Additionally, there were some complaints due in early September that were delayed due to Hurricane Harvey.
- BCBS stated they are facing significant staffing challenges resulting in an increased volume of delayed cases. They are working through process improvement efforts to improve the timeliness of the process and reduce handoffs. HHSC has recommended LDs.
- FirstCare stated that there was one appeal that was resolved on the 31st day. The case was late as it required a second review by the physician and was missed due to the oversight of the documentation sent. FirstCare indicates it will re-educate the team to ensure specific requested documentation is flagged for provider review.
- Molina reported that a resolution letter was sent late, but the complaint had already been resolved. It was determined that the letter was inadvertently placed in the wrong folder and the issue has been addressed with team members.

Member Appeals

- Six MCOs did not meet the 30-day resolution standard for member appeals: BCBS (Travis SDA) Community 1st (Bexar SDA), First Care (Lubbock SDA), Molina (Dallas SDA) and Texas Children's (Harris SDA).
- First Care stated that one appeal was resolved on day 31, which caused the non-compliance.
- Cook reported that one appeal missed the timeline due to a data entry error in calculating the resolution due date. The daily report has been reconfigured to automatically calculate the appeal resolution due date and the manager reviews the resolution due date on a daily basis to ensure timely completion of letters.
- Molina reported that a resolution letter was sent on the 31st day instead of the 30th day and the issues has been addressed with the responsible parties and the process has been revised to include a weekly certificate of appeals due sent on Friday instead of Mondays to allow for better staffing and preparation for upcoming cases.
- Texas Children's reported that one appeal was resolved beyond 30 days due to the reminder system failing and dropping the appeal request from the work queue.

Provider Complaints

- All STAR MCOs achieved compliance with provider complaints resolved 100% within 30 days with the exception of BCBS.

2018 SFQ1 (September - November)

Member Complaints

- Two STAR MCOs did not meet the benchmark for the timely resolution of member complaints: Superior (Lubbock SDA), and Texas Children's (Harris, and Jefferson SDA).
- Superior explained there was a staff oversight with timely submission of a translation request for a resolution letter and has been addressed.
- Texas Children's reported improvement from 2017 Q4 shifting closer to the 98% and explained the complaints department has added new staff and is currently in the process of revising internal processes for more timely resolution of the increasing volume of incoming complaints.

Member Appeals

- Four MCOS did not meet the benchmark for timely resolution of member appeals: BCBS (Travis SDA), Superior (El Paso SDA), Texas Children's (Harris SDA), and United (Harris SDA).
- BCBS reported the appeals process was moved to a new area in the company and they are working on providing new training including workforce requirements.
- Texas Children's reported four appeals resolved beyond 30 days due to a lack of timely follow up with the physician assigned to review the appeal. The MCO has implemented additional reminders for physicians and leadership at 20 days after appeal received to ensure a decision is rendered on or before the 30th day.
- Superior reported a staffing shortage and a system issue.
- United states they have reinforced timelines with staff and implemented additional monitoring, reporting and f**o**llow-up on a weekly basis.

Provider Complaints

- Two MCOS did not meet the benchmark for timely resolution of provider complaints: BCBS (Travis SDA) and Superior (Travis SDA).
- Superior explained there was a staff oversight with timely submission of a translation request for a resolution letter and this has been discussed with staff.

STAR+PLUS

2017 SFQ4 (June - August)

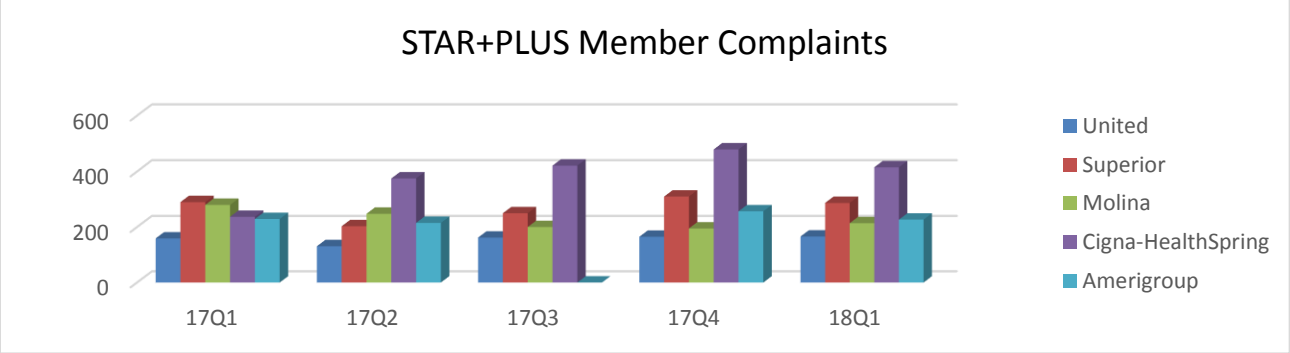
The total number of STAR+PLUS complaints and appeals increased from 3,981 in 2017 SFQ4 to

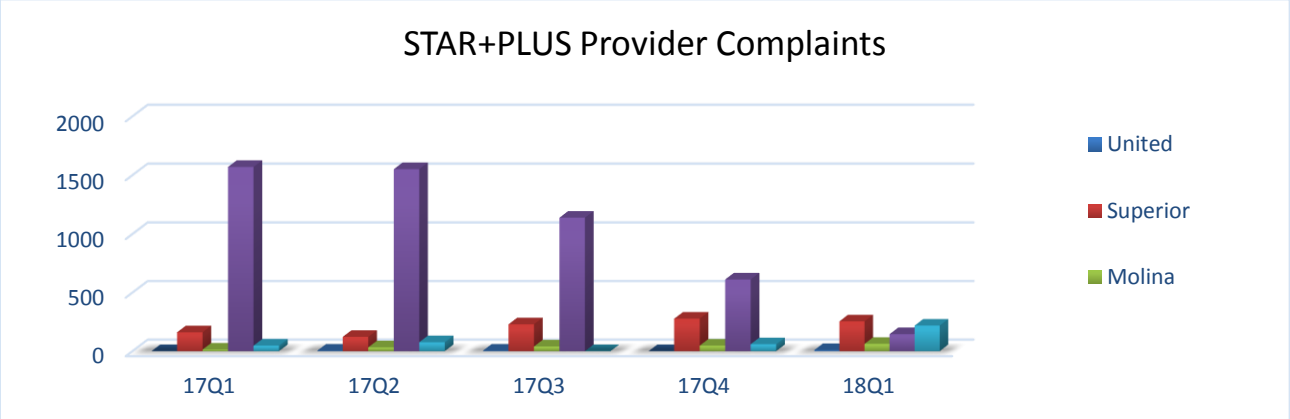
4,621 in 2017 SFQ4. STAR+PLUS plans reported 1,406 member complaints, 2,220 member appeals and 995 provider complaints in 2017 SFQ4.

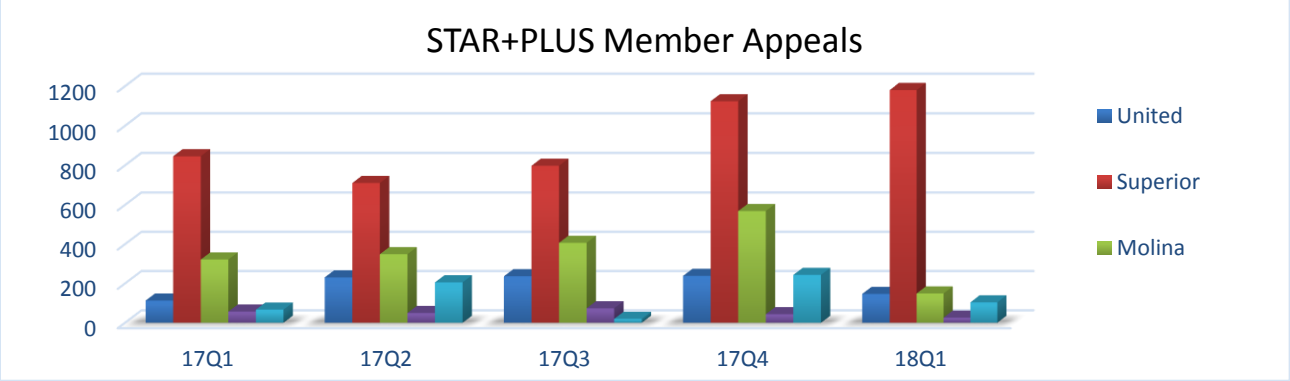
2018 SFQ1 (September - November)

The total number of STAR+PLUS complaints and appeals decreased from 4,621 in 2017 SFQ4 to 3,604 in 2018 SFQ1. STAR+PLUS plans reported 1,309 member complaints, 1,607 member appeals and 688 provider complaints in 2017 SFQ4.

Complaints and Appeals Received by STAR+PLUS MCOs (2017 SFQ1 – 2018 SFQ1)







2017 SFQ4 (June - August)

Member Complaints

- All STAR+PLUS MCOs achieved compliance with the timely resolution of member complaints with the exception of Molina (El Paso, Hidalgo, and Jefferson SDAs).
- Molina reported resolution letters were not sent timely and that the process has been adjusted to have the due date set for the 28th calendar date instead of the 30th.

Member Appeals

- All STAR+PLUS MCOs were in compliance with member appeal standards.

Provider Complaints

- Molina (Dallas SDA) was the only STAR+PLUS MCO that failed to meet compliance standards for provider complaints.

2018 SFQ1 (September - November)

Member Complaints

- All STAR+PLUS MCOs were in compliance with member complaint standards.

Member Appeals

- Only one STAR+PLUS MCO did not meet the benchmark for timely resolution of member appeals: United (Harris, MRSA Central, and MRSA Northeast SDAs).
- United reported staffed have received extensive coaching and re-education. HHSC has recommended LD's for these non-compliances.

Provider Complaints

- United (MRSA Northeast) was the only MCO to not meet the benchmark for timely resolution of provider complaints in both.
- United reported for MRSA Northeast, staff were re-educated on timeframes and additional monitoring will occur to ensure any at risk cases are identified for resolution within 30 days.

STAR Kids

2017 SFQ4 (June - August)

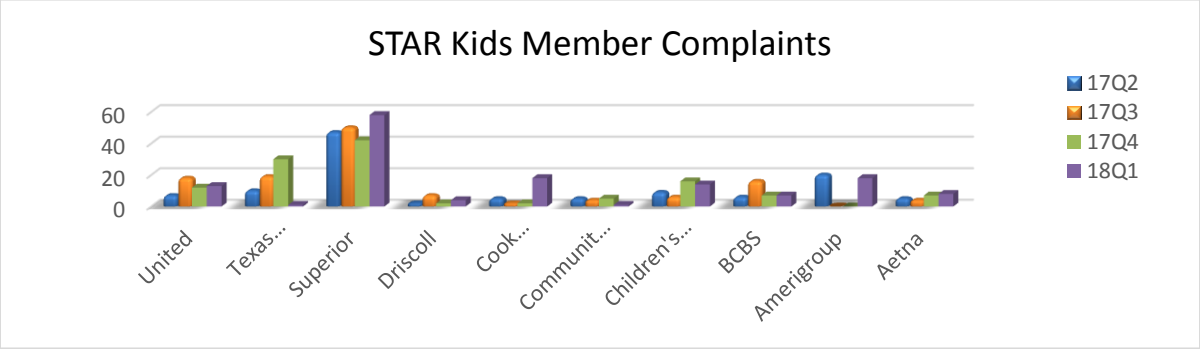
The total number of STAR Kids program complaints and appeals was 1,134 in 2017 SFQ4, an

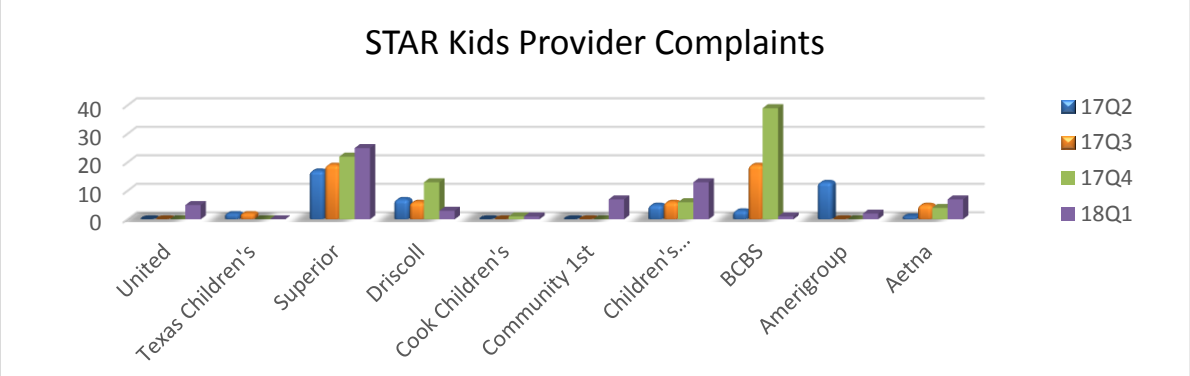
increase from 820 in 2017 SFQ3. STAR Kids plans reported 123 member complaints, 926 member appeals and 85 provider complaints in 2017 SFQ4.

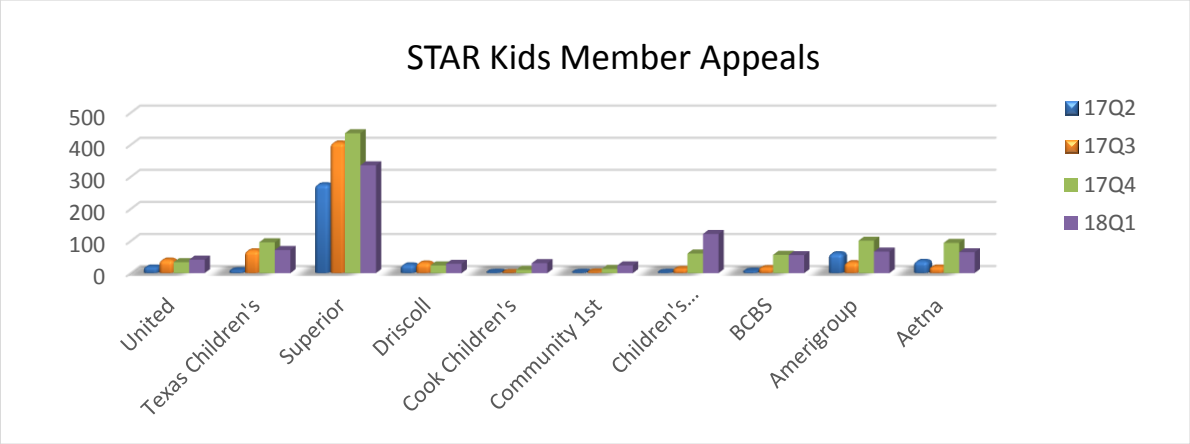
2018 SFQ1 (September - November)

The total number of STAR Kids program complaints and appeals decreased from 1,134 in 2017 SFQ4 to 1,050 in 2018 SFQ1. STAR Kids plans reported 142 member complaints, 844 member appeals and 64 provider complaints in 2018 SFQ4.

Complaints and Appeals Received by STAR Kids MCOs (2017 SFQ1 – 2018 SFQ1)







2017 SFQ4 (June - August)

Member Complaints

- All MCOs met the standard for member complaints with the exception of Texas Children's (Harris and MRSA Northeast SDAs).
- Texas Children's stated there was a staffing change in the complaints role which caused cases to be addressed outside of the 30 day standard. There were also some complaints due in early September that were delayed due to Hurricane Harvey.

Member Appeals

- Four MCOs did not meet the standard for member appeals: Superior (Travis SDA), Texas Children's (Harris SDA), United (MRSA Central SDA) and BCBS (MRSA Central and Travis SDAs).
- BCBS stated they are facing significant staffing challenges resulting in an increased volume of delayed cases. They are swiftly working to address staffing concerns by posting and hiring additional roles to train and ramp up and also implementing process improvement efforts to improve the timeliness of the process while reducing handoffs. BCBS indicated they are making gains in process efficiency that will positively impact their ability to be timely.
- Superior stated that those completed outside of the 30-day timeframe were due to the appeals coordinator using the incorrect due date. Superior indicated this issue should resolve itself with the integration to physical health and streamlining the reporting methods. Additionally, they now have BH appeals added to the appeals report that pulls directly from TruCare so the due date no longer has to be manually calculated.
- United indicated one behavioral health appeal resolution letter was sent outside the 30-day timeframe (sent on 31st day). The MCO provided re-education to the behavioral health appeals team and has added additional monitoring and reporting for at-risk cases to ensure 30-day compliance.

Provider Complaints

- All MCOs met the standard for member complaints with the exception of BCBS. BCBS explained that they are in the process of restricting this department, including additions to staff which will improve timeliness.

2018 SFQ1 (September - November)

Member Complaints

- All MCOs met the standard for member complaints with the exception of BCBS (Travis SDA).

Member Appeals

- Three MCOs did not meet the standard for member appeals: BCBS (MRSA Central and Travis SDAs), Cook (Tarrant SDA), and United (Hidalgo SDA).
- BCBS reported the appeals process was moved to a new area in the company and they intend to provide new training including workforce requirements.
- Cook reported they have seen an increase in appeals with the end of continuity of care provisions and have redistributed work to make the process more efficient.
- United indicated clarification and re-training on the requirements to staff would be provided.

Dental

2017 SFQ4 (June - August)

Between 2017 SFQ3 and 2017 SFQ4, dental member complaints increased from 163 in SFQ3 to 201 in SFQ4, member appeals decreased from 247 in SFQ3 to 298 in SFQ4, and provider complaints decreased from 21 in SFQ3 to 37 in SFQ4.

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 2017 SFQ4 with the exception of DentaQuest failing to meet timely resolution of member complaints (96.20%). DentaQuest indicated non-compliance was due to internal mail processing issues.

2018 SFQ1 (September - November)

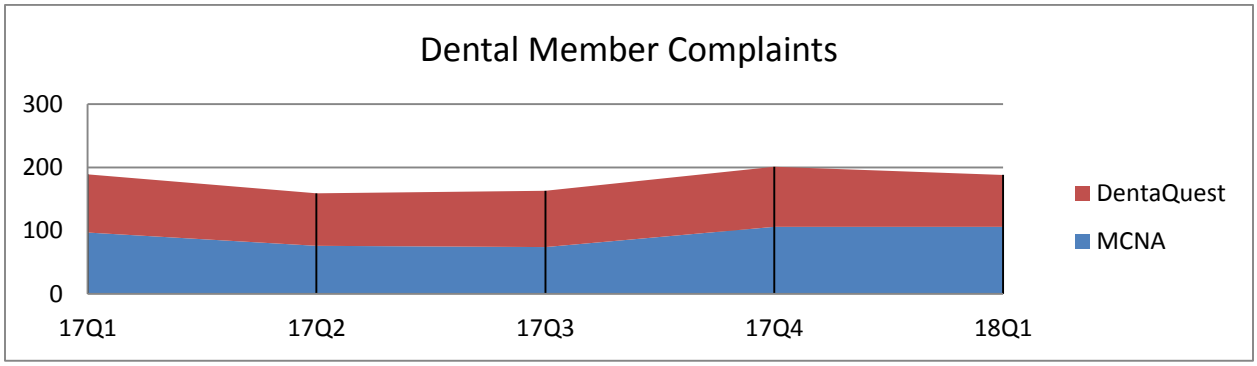
Between 2017 SFQ4 and 2018 SFQ1, dental member complaints decreased from 201 in 2017 SFQ4 to 188 in 2018 SFQ1, member appeals decreased from 298 in 2017 SFQ4 to 248 in 2018 SFQ1, and provider complaints increased from 37 in 2017 SFQ4 to 42 in 2018 SFQ1.

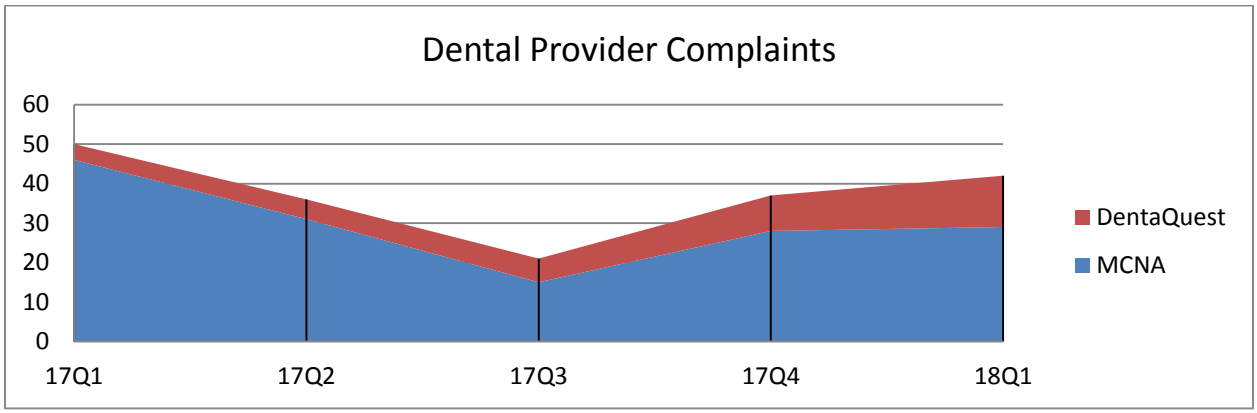
Complaints and appeals are reported in aggregate for each statewide dental plan.

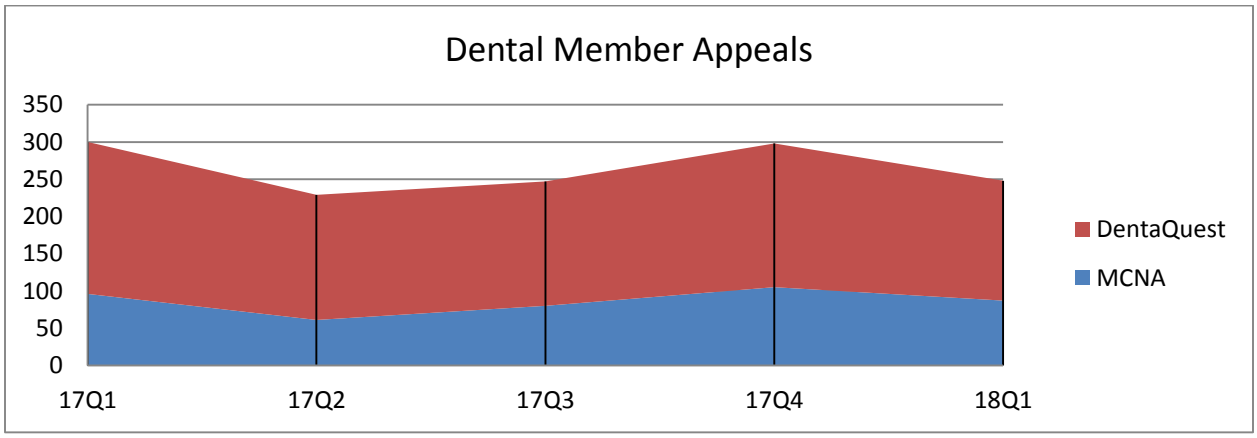
MCNA and DentaQuest met all performance standards for the timely resolution of complaints and appeals in 2018 SFQ1 with the exception of DentaQuest failing to meet timely resolution of provider complaints (90.9%).

- DentaQuest stated the non-compliance was due to internal routing and processing issues in the system. DentaQuest further indicated this was an isolated incident; however, they did implement process changes.

Complaints and Appeals Received by DMOs (2017 SFQ1– 2018 SFQ1)







C. COMPLAINTS RECEIVED BY THE STATE

Attachment O includes information concerning Dental, STAR, STAR Kids, 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 Managed Care Compliance and Operations (MCCO) team. Members can also call in to submit member and provider complaints through the Office of the Ombudsman via the Medicaid Managed Care Helpline (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).

STAR

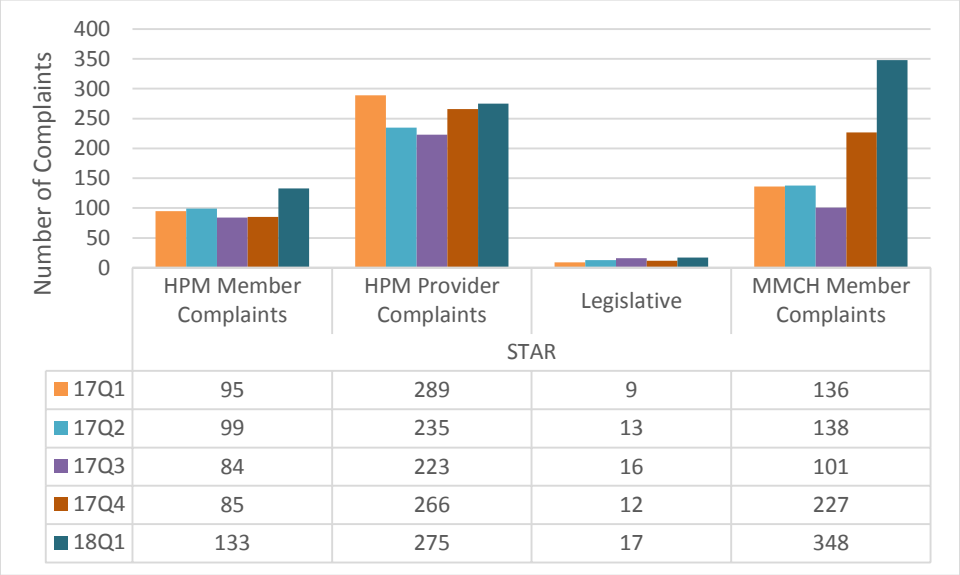
2017 SFQ4 (June - August)

In the STAR program, the number of member complaints received by MCCO remained relatively constant 1.19% (84 in 2017 SFQ3 and 85 in 2017 SFQ4) and the number of member complaints received by MMCH increased by 124.75% from 101 in 2017 SFQ3 to 227 2017 SFQ4. HPM received 12 contacts on behalf of members from legislative representatives. The most common member complaints received by MCCO and MMCH were issues with access to care, member claims, and billing and prescription related issues. The number of provider complaints received by MCCO increased by 19.28% (from 223 to 266) in 2017 SFQ4. The most common type of provider complaints received by MCCO was denial of claim.

2018 SFQ1 (September - November)

In the STAR program, the number of member complaints received by MCCO increased by 56.47% (85 in 2017 SFQ4 and 133 in 2018 SFQ1) and the number of member complaints received by MMCH increased by 53.30% from 227 in 2017 SFQ4 to 348 2018 SFQ1. MCCO received 17 contacts on behalf of members from legislative representatives. The most common member complaints received by MCCO and MMCH remained issues with member claims, access to care, and billing and prescription related issues. The number of provider complaints received by MCCO increased by 3.38% (from 266 to 275) in 2018 SFQ1. The most common type of provider complaints received by MCCO remained denial of claim.

Complaints to the State Regarding STAR (2017 SFQ1 - 2018 SFQ1)



	HPM Member Complaints	HPM Provider Complaints	Legislative	MMCH Member Complaints
17Q1	95	289	9	136
17Q2	99	235	13	138
17Q3	84	223	16	101
17Q4	85	266	12	227
18Q1	133	275	17	348

STAR+PLUS

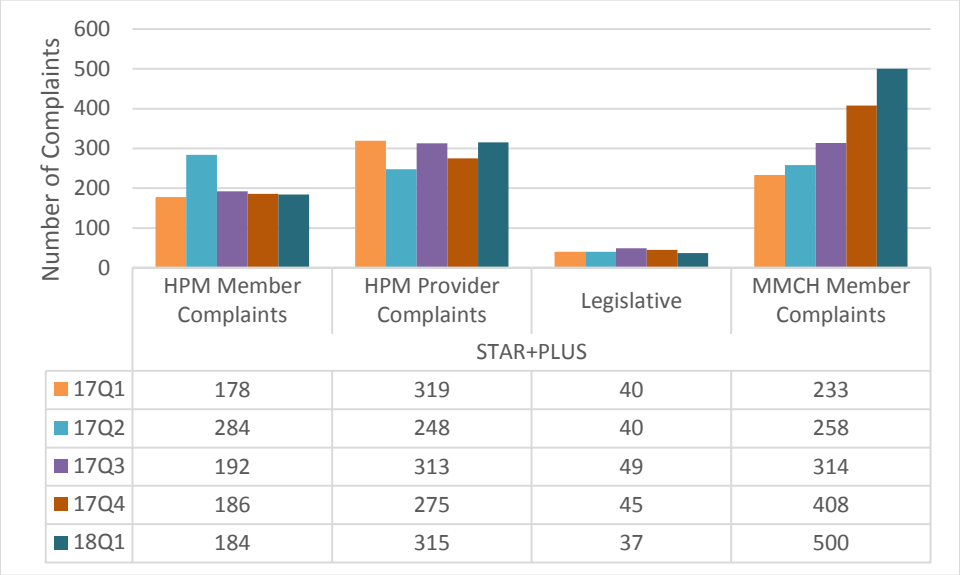
2017 SFQ4 (June - August)

Across the STAR+PLUS program, the number of member complaints received by MCCO decreased by 3.13% (192 to 186) from 2017 SF3 to SFQ4. The member complaints received by MMCH increased by 29.94% (314 to 408). MCCO received 45 contacts on behalf of members from legislative representatives. The most common issues of member complaints received by MMCH and MCCO were issues with benefits, access to care, and billing issues. The number of provider complaints decreased by 12.14% (313 to 275) from 2017 SFQ3 to SFQ4.

2018 SFQ1 (September - November)

Across the STAR+PLUS program, the number of member complaints received by MCCO decreased by 1.08% (186 to 184) from 2017 SF4 to 2018 SFQ1 and the member complaints received by MMCH increased by 22.55% (408 to 500). MCCO received 37 contacts on behalf of members from legislative representatives. The most common issues of member complaints received by MMCH and MCCO were issues with benefits, access to care, durable medical equipment, and billing issues. The number of provider complaints increased by 14.55% (275 to 315) from 2017 SFQ4 to 2018 SFQ1.

Complaints to the State Regarding STAR+PLUS (2017 SFQ1 - 2018 SFQ1)



	HPM Member Complaints	HPM Provider Complaints	Legislative	MMCH Member Complaints
17Q1	178	319	40	233
17Q2	284	248	40	258
17Q3	192	313	49	314
17Q4	186	275	45	408
18Q1	184	315	37	500

STAR Kids

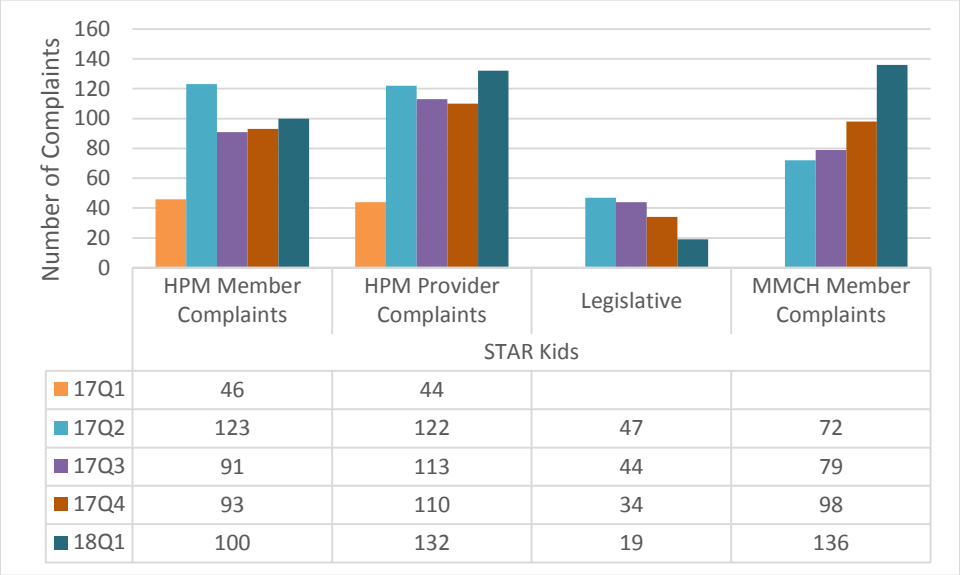
2017 SFQ4 (June - August)

Across the STAR Kids program, the number of member complaints received by MMCH increased by 24.05% (79 to 98) from 2017 SFQ3 to SFQ4 and the member complaints received by MCCO increased by 2.20% (91 to 93). MCCO received 34 contacts on behalf of members from legislative representatives. The most common issues of member complaints received by MMCH and MCCO were issues with benefits and access to care. The number of provider complaints decreased by 2.65% (113 to 110) from 2017 SFQ3 to SFQ4.

2018 SFQ1 (September - November)

Across the STAR Kids program, the number of member complaints received by MMCH increased by 38.78% (98 to136) from 2017 SFQ4 to 2018 SFQ1. The member complaints received by MCCO increased by 7.53% (93 to 100). MCCO received 19 contacts on behalf of members from legislative representatives. The most common issues of member complaints received by MMCH and MCCO were issues with benefits, prescriptions, and access to care. The number of provider complaints decreased by 20% (110 to 1332) from 2017 SFQ4 to 2018 SFQ1.

Complaints to the State Regarding STAR Kids (2017 SFQ1 - 2018 SFQ1)



	HPM Member Complaints	HPM Provider Complaints	Legislative	MMCH Member Complaints
17Q1	46	44		
17Q2	123	122	47	72
17Q3	91	113	44	79
17Q4	93	110	34	98
18Q1	100	132	19	136

Dental Program

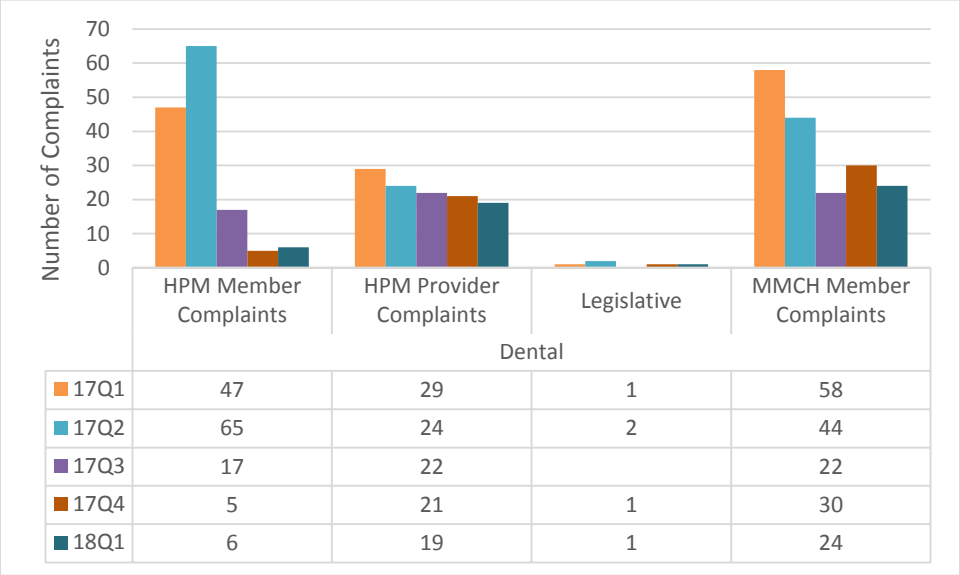
2017 SFQ4 (June - August)

Across the Dental Program, the number of member complaints received by MMCH decreased by 36.36% (22 to 30) from 2017 SFQ4. The number of member complaints received by MCCO decreased 70.59% (17 to 5) in 2017 SFQ4. The most common member complaint issues received were regarding billing or authorization. The most common provider complaint issue received was denied claims. Provider complaints decreased by 4.55% (22 to 21) from 2017 SFQ3 to SFQ4.

2018 SFQ1 (September - November)

Across the Dental Program, the number of member complaints received by MMCH decreased by 20% (30 to 24) from 2018 SFQ1. The number of member complaints received by MCCO increased by 20% (5 to 6) from 2018 SFQ1. The most common member complaint issue received were regarding authorization. The most common provider complaint issue remained denial of claims. Provider complaints decreased by 9.52% (21 to 19) from 2017 SFQ4 to 2018 SFQ1.

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



	HPM Member Complaints	HPM Provider Complaints	Legislative	MMCH Member Complaints
17Q1	47	29	1	58
17Q2	65	24	2	44
17Q3	17	22		22
17Q4	5	21	1	30
18Q1	6	19	1	24

XI. QUALITY ASSURANCE/MONITORING ACTIVITY

This section covers quality assurance and monitoring activities that occurred in DY6 SFQ4 and DY7 SFQ1.

A. DY6 QUARTER 4 UPDATE

Beginning in August, Texas's external quality review organization (EQRO), the Institute for Child Health Policy at the University of Florida (ICHP) began visiting the MCOs and DMO scheduled for an Administrative Interview (AI) site visit for 2017. The AI evaluates each plan participating in Medicaid Managed Care and CHIP on elements important to the provision of quality care and service to members, as well as compliance with state and federal regulations. Each plan has an AI site visit conducted every three years.

Each year ICHP conducts a review of the Quality Assessment and Performance Improvement (QAPI) program of participating health plans to assess elements reflecting the plan's ability to address regulations and assess the strength of the plans' Quality Improvement program. By the beginning of August, HHSC provided the annual QAPI program summary report evaluations to the MCOs and DMOs.

On September 1, 2017, the redesigned medical and dental pay-for-quality (P4Q) programs Uniform Managed Care Manual (UMCM) chapters were finalized for measurement year 2018. The UMCM chapters outline the measures, methodology, and technical specifications for the programs, allowing plans time to prepare before the measurement year begins. HHSC's redesigned

medical P4Q program creates financial incentives and disincentives for health plans based on their performance on a set of quality measures. Under P4Q, a percentage of the health plan's capitation is at risk based on their performance on a number of key metrics. The redesigned dental P4Q program incentivizes continued excellent performance by recouping from the dental plans capitation at risk if performance declines.

On September 21, 2017, HHSC announced to MCOs that the structure and rating system would be changing for the 2017 report cards. The changes will improve readability and more accurately assess health plan performance. The changes included using a five-star rating system instead of a three-star and shifting from percentile based rating to cluster-based rating.

On July 3, 2017, ICHP began fielding the contract year 2016 Behavioral Health Appointment Availability Study. In August, results for the 2016 Vision sub study were presented to the MCOs via conference call.

The 2018 Appointment Availability Study proposal was finalized in September 2017. As with the 2016 Study, the EQRO will conduct secret shopper calls to providers to determine appointment availability and wait times for Medicaid primary care, behavioral health, OBGYN, and vision providers throughout the state. The 2018 Study will include STAR Health and STAR Kids programs for the first time, in addition to STAR, CHIP and STAR+PLUS.

On July 11, 2017, HHSC and ICHP held the first of four workshops to assist MCOs in planning their 2018 Performance Improvement Projects (PIPs). MCOs submitted their 2018 PIP plans on September 1, 2017. On September 30, 2017 the MCOs submitted final PIP reports for 2014 three-year PIPs.

B. DY7 QUARTER 1 UPDATE

In November, HHSC and Texas's EQRO, ICHP, hosted the Medicaid/CHIP Managed Care Quality Forum. This two-day conference provides Texas Medicaid and CHIP health plans with the opportunity to learn about current HHSC quality-related initiatives and best practices. Presentations included:

- Texas Quality Strategic Goals and Vision
- Comparative View of Texas' Quality Results versus other States and Nationally and alignment with current and/or future Texas Quality Strategies
- P4Q Medical and Dental Methodology Discussion
- Texas Healthcare Learning Collaborative Portal: Use Of New Technology for Quality Monitoring and Metrics in Improved Patient Care
- Precision Population Health: Opportunities for Texas

- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- National Core Indicators for Individuals with Disabilities in Texas
- What Do We Know About High-Cost and High-Use Children in Texas Medicaid?
- The Opioid Epidemic and Texas Medicaid Efforts to Reduce Prescription Opioid Abuse and Overutilization

There were also breakout sessions on:

- Implementation Science Strategies to Improve Quality of Care: Antipsychotic Use as a Case Study
- Dental Quality of Care: Measuring Quality and Outcomes of Care
- Evidence-Based Best Practices for Post-Partum Care
- High Risk Populations: Enrollees with Co-Occurring Physical and Mental Health Conditions
- Community Rx: Geocoding and Social Determinants of Health
- Evidence-Based Best Practices for Diabetes Care

ICHP produced the final calendar year 2016 quality of care reports which include health plan level results on Healthcare Effectiveness Data and Information Set (HEDIS) measures and Association for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDI) and Prevention Quality Indicators (PQI) measures. These results were shared with the health plans in October.

In October, ICHP concluded visiting the 10 MCOs and DMO scheduled for an Administrative Interview (AI) site visit for 2017. The AI evaluates each plan participating in Medicaid Managed Care and CHIP on elements important to the provision of quality care and service to members, as well as compliance with state and federal regulations. Each plan has an AI site visit conducted every three years.

In November, the 2016 Primary Care Appointment Availability Sub Study report and data tables were finalized, and in December, the data was finalized for the 2016 Behavioral Health Appointment Availability Sub Study.

Data collection for the National Core Indicators--Aging and Disabilities (NCI-AD) survey in Houston and Corpus Christi was adversely affected by Hurricane Harvey. As a result, the number of pre-screen call attempts required before the face-to-face visit was reduced. As of the end of March, approximately 98 percent of the target has been completed.

The HHSC Performance Indicators Dashboards for Quality Measures have been modified. In November, the 2017 measures and standards were added to the UMCM, including measures for STAR Kids. For 2018 and forward, HHSC set a minimum standard and a high performance standard. MCO performance will be compared to these standards and those who do not meet the minimum standard on one-third or more of the measures will be subject to corrective action plans.

HHSC created new UMCM chapter 10.1.14, which describes the methodology for setting standards. Measures and standards will no longer be in the UMCM and instead will be posted on the Texas Healthcare Learning Collaborative Portal.

MCOs and DMOs submitted their 2018 performance improvement project (PIP) plans for 2018 and ICHP evaluated and provided feedback on the plans. HHSC and ICHP held technical assistance calls with the health plans that scored five or more points below average on their PIP plans. All MCOs resubmitted their PIP plans after incorporating ICHP's feedback. Topics include:

- Increase the timeliness of prenatal care and/or improve the rate of postpartum care;
- Decrease potentially preventable ED visits for upper respiratory tract infection; and
- Increase rates of weight assessment and counseling for nutrition and physical activity.

C. ANNUAL UPDATE

Quality Forum

In December 2016, HHSC and its EQRO, ICHP, hosted the annual Medicaid/CHIP Managed Care Quality Forum. The event included presentations related to the Texas Healthcare Learning Collaborative (THLC) portal, measuring quality in long term supports and services, pediatric quality measures and electronic health record pilot, developing performance improvement project (PIP) interventions, STAR Kids pre-implementation, and the effect of transition to managed care on foster youth.

Report Cards

HHSC released updated MCO report cards to help members of STAR, STAR+PLUS and CHIP 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 2016 reports cards were made available to members on the HHSC website and included in the enrollment packets sent to all newly eligible members. The measures will continue to be reviewed and updated annually.

Appointment Availability Studies

As part of an initiative to examine ways to improve network adequacy in Medicaid managed care, HHSC contracted with ICHP 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, CHIP 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.

THLC Portal

The THLC portal, at https://thlcportal.com/home, has been updated with a new look and to include trending data on Medicaid healthcare quality. In addition to quality data, the THLC portal has become a convenient place for MCOs to find other quality information, for example, PIP workshop materials and HHSC Performance Indicators and standards. HHSC and ICHP continue to work closely to improve the tool.

Administrative Interviews

HHSC received the EQRO's Administrative Interview evaluations and participated in the local site visits held August 14-16, 2017. Texas's EQRO conducted the remaining administrative interviews with nine of the State's health plans and one dental plan from August through December, and HHSC participated via telephone. The site visits focused on timelines for grievances, appeals, and fair hearings, services for migrant farm workers, postpartum programs, care coordination and disease management programs for members with chronic conditions, clinical indicator monitoring, and for those applicable plans implementation of STAR Kids.

Quality Assessment and Performance Improvement Programs

The health plans submitted their Quality Assessment and Performance Improvement (QAPI) program summary for calendar year 2016 to Texas's EQRO. The EQRO evaluated the QAPI reports and HHSC reviewed these reports and shared them with the health plans.

Pay-for-Quality

In May, the Executive Commissioner approved the redesigned medical Pay-for-Quality (P4Q) measures and methodology for calendar year 2018. HHSC's redesigned medical P4Q program creates financial incentives and disincentives for health plans based on their performance on a set of quality measures. Under P4Q, a percentage of the health plan's capitation is held at risk based on their performance on a number of key metrics. In June 2017, HHSC shared draft technical specifications with the managed care organizations (MCOs) and allowed comments to be submitted through the end of the month.

In June, the Executive Commissioner approved the redesigned dental Pay-for-Quality program,

and HHSC shared draft technical specifications for the program with the dental maintenance organizations (DMOs). The redesigned dental P4Q program incentivizes continued excellent performance by recouping from the dental plans capitation at risk if performance declines. HHSC accepted comments from the DMOs on the redesigned program and will share responses to comments next quarter.

On September 1, 2017, the redesigned medical and dental Pay-for-Quality (P4Q) programs Uniform Managed Care Manual (UMCM) chapters were finalized for measurement year 2018. The UMCM chapter outlines the measures, methodology, and technical specifications for the programs, allowing plans plenty of time to prepare before the measurement year begins.

Performance Improvement Projects

In July, HHSC and ICHP held a PIP workshop for the health plans. Topics included how to use potentially preventable event measures for PIPs, statistical analysis for multiple data years, lessons learned from 2014 two-year PIPs, introduction of a statewide superutilizer PIP for 2019.

For the 2018 PIPs, health plans submitted their PIP plans to address:

- STAR and STAR+PLUS- Improve rates of timeliness of prenatal care, postpartum care and/or frequency of prenatal care
- STAR Kids - Decrease potentially preventable ED visits for upper respiratory tract infection
- Dental - Increase utilization of sealants

Two of the STAR+PLUS plans are conducting a self -directed care pilot for their 2018 PIP. These topics align with other HHSC quality initiatives and continue our focus on prevention and maternal and infant health. For the STAR and STAR+PLUS plans, HHSC held a workgroup for those interested in focusing on a subpopulation or subtopic (e.g., pregnant women with substance use disorders, behavioral health services for pregnant and postpartum women). The workgroup was a forum for health plans to discuss their areas of interest and how a more focused PIP could be operationalized.

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 National Core Indicators-- Aging and Disabilities (NCI-AD) survey. The NCI-AD is an in-person survey that collects information on the experiences of individuals who are aging or have a physical disability

and are receiving long-term services and supports (LTSS). Texas is one of 20 states currently participating in this effort. As part of this initiative, HHSC voluntarily reports the results to NASUAD. The Texas report can be found on the NCI-AD website at: https://nci-ad.org/states/TX/

Quality Measurement

HHSC received the annual HEDIS and potentially preventable events (PPE) data from ICHP for measurement year 2015. These results were loaded onto the THLC portal. Throughout the year, HHSC received CAHPS survey results for STAR Health, STAR+PLUS, and STAR adult.

STAR Kids implementation

As part of the implementation of STAR Kids, ICHP is conducting a pre and post implementation study. For the pre-implementation study, ICHP conducted a survey of caregivers of individuals eligible for STAR Kids prior to implementation and ran administrative quality measures using 2014 and 2015 data. The pre-implementation study report was finalized and shared with stakeholders. ICHP will compare results with the post-implementation data.

XII. DEMONSTRATION EVALUATION

This section addresses the quarterly reporting requirements in STC 71 and 75, regarding evaluation activities and issues.

A. OVERVIEW OF EVALUATION

This quarterly report reflects evaluation activities from July 1, 2017, through December 31, 2017.

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 examined 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 was on obtaining and monitoring data on performance measures for short-term (process measures) and intermediate (health outcomes) of the Program. The performance measures were used to assess the extent to which the Program accomplished its goals, tracked changes from year to year, and identified opportunities for improvement.

The Texas Healthcare Transformation and Quality Improvement Program (Demonstration) was initially approved by CMS in December 2011 through September 30, 2016. A 15-month extension was granted from October 1, 2016 through December 31, 2017. The current version of the Demonstration was approved on December 21, 2017, renewing the waiver for five years through September 30, 2022.

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

DY6 Q4 July - September

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

1. The contract between HHSC Center for Analytics and Decision Support (CADS) and Texas A&M terminated April 30, 2017. All deliverables were received and there has been no further joint evaluation activities.

HHSC Evaluation Activities: Interventions I & II

General Evaluation Activities

1. HHSC CADS evaluation staff submitted the Final Evaluation Report and Technical Response Document to CMS on May 30, 2017, as required by STC 75(b).
2. HHSC CADS evaluation staff attended project meetings and scheduled monthly CMS calls.

Intervention I

1. The abstract accepted for oral presentation at the American Public Health Association Annual Meeting and Expo (annual conference), *Impacts of Texas Medicaid policy change on adult access to ambulatory health services for aged and disabled population*, was nominated for the Rural and Environment Research Award. A journal-style manuscript was submitted for consideration on August 4, 2017. The conference was November 4-8, 2017 in Atlanta, GA.

Intervention II

1. HHSC CADS members no longer meet with Texas A&M team members as the contract has been fulfilled.

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

1. The evaluation report for the Integrating Primary Care into Behavioral Health Settings for Adults with SPMI was finalized based on feedback from all stakeholders. The SPMI evaluation report and a separate executive summary were submitted to HHSC CADS, Meadows Mental Health Policy Institute of Texas, and community mental health center partners on May 4, 2017.
2. The SPMI final evaluation report and executive summary documents were shared with the HHSC Transformation Waiver Team.

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

1. Evaluation findings for the Integrating Primary Care into Behavioral Health Settings for Adults with SPMI was submitted to HHSC CADS and has been reviewed by the HHSC Transformation Waiver team.

Challenges or Issues Encountered

No challenges or issues were encountered this quarter.

DY7 Q1 October - December

HHSC Evaluation Activities:

1. HHSC CADS evaluation staff attended project meetings and scheduled monthly CMS calls.
2. HHSC CADS evaluation staff provided written feedback to CMS on the Demonstration renewal STCs, Appendix O: Preparing the Evaluation Plan, and Appendix P: Preparing the Evaluation Report.
3. HHSC CADS evaluation staff began drafting the Evaluation Design Plan, which when approved by CMS, will be included as STC Appendix S: Evaluation Design.
4. HHSC CADS evaluator, Dr. Tenaya Sunbury, presented at the American Public Health Association Annual Meeting and Expo (annual conference), *Impacts of Texas Medicaid policy change on adult access to ambulatory health services for aged and disabled population*. The conference was November 4-8, 2017 in Atlanta, GA.

Challenges or Issues Encountered

No challenges or issues were encountered this quarter.

C. ACTIVITIES PLANNED IN NEXT QUARTER

January 1, 2018 through March 31, 2018

1. HHSC CADS will attend project meetings and CMS calls.

HHSC CADS Evaluation Unit

1. HHSC CADS will continue to address evaluation-related questions as they arise with respect to amendments and any extension/continuation of the waiver.
2. HHSC CADS will meet with internal 1115(a) Demonstration waiver stakeholders to discuss proposed evaluation measures.
3. Internal routing of the draft Evaluation Design Plan will begin February 28, 2018 for a CMS submission due date of April 19, 2018.

Communication, Dissemination, and Reporting

1. Previous external evaluators continue to revise the hospital level record linkage manuscript for resubmission.

XIII. REGIONAL HEALTHCARE PARTNERSHIP PARTICIPANTS

This section addresses the quarterly and annual reporting requirements in STC 71 and 72.

A. ACCOMPLISHMENTS

1. Major DSRIP Activities during Federal Fiscal Quarter 1/2017 (10/01/2016-12/31/2016)

Preparing for and processing October DY5 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 58.6 percent of the 9,084 DY4-DY5 Category 1-4 milestones/metrics. HHSC approved 95 percent of the reported milestones/metrics for a total of $2,059,981,339 in approved DSRIP payments. Based on available IGT, $2,053,211,878 was paid for DSRIP in January 2017, for a total of $9.9 billion in DY1-DY5 DSRIP payments to date. An additional reporting period for metrics requiring additional information (Needs More Information or NMI) to substantiate achievement opened in December and closed in January 2017. Metrics approved during the NMI reporting period will be paid in July 2017, contingent on available IGT.

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 2017.

Significant work continued in Q1 on negotiations with CMS on continuation of the waiver. On October 21, 2016, a face-to-face meeting occurred in Washington, DC between HHSC and CMS. Key areas for negotiations include the size of the Uncompensated Care pool, size and evolution of the DSRIP pool, and integration of DSRIP into the managed care delivery model for Texas Medicaid. HHSC and CMS continued discussions via conference calls during Q1.

HHSC staff developed a draft Sustainability Planning template for provider reporting in DY6 and sent it out for stakeholder feedback. Providers will be required in DY6 to report on their efforts toward sustainability of their projects and outcomes. HHSC staff also continued planning for continuation of the waiver in DY7 and beyond to include updated protocols for DSRIP participation requirements for performing providers that evolve the transformational work

accomplished during the initial waiver period and 15-month extension.

HHSC continued stakeholder communications in Q1 through webinars, biweekly Anchor calls, and reporting companion documents. On October 5, 2017, HHSC held a webinar on DSRIP October DY5 reporting for providers.

2. Major DSRIP Activities during Federal Fiscal Quarter 2/2017 (01/01/2017-03/31/2017)

In late January and early February of 2017, HHSC staff reviewed provider responses to metrics that were found to need more information to support achievement during October DY 5 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 2017. For project metrics achieved during the October DY5 reporting period (including DY4 carryforward metrics), DSRIP providers received about $2.05 billion (based on available IGT) in January 2017.

HHSC completed review of the anchor administrative cost reports submitted during Q1. IGT was requested by January 27th with payments to anchors made February 10, 2017. HHSC also sent out amendments to the anchor administrative contracts, which will extend the current contracts through September 30, 2018. In DY6, anchors will receive a one-time Anchoring Entity allocation in lieu of anchor administrative payments.

In January, HHSC requested an additional 21 months of level funding for the Uncompensated Care and DSRIP pools, and a continuation of the managed care provisions of the 1115 waiver. This request was made to allow the new administration and the 115th Congress to make changes to the nation's health care system and the Medicaid program during 2017. It also allows the 86th Texas Legislature to respond to any federal changes.

Related to the request for an additional 21 months, during Q2, HHSC posted on the waiver website draft language for the Program Funding and Mechanics (PFM) Protocol proposed for DY7-8. A survey was available for stakeholder feedback on the proposed language. HHSC staff are in the process of reviewing stakeholder feedback and developing responses and any PFM changes.

One of the proposed changes for DY7-8 for DSRIP is movement from project-level reporting to targeted Measure Bundles that are reported by DSRIP performing providers as a provider system. HHSC worked with the Clinical Champions to develop a process for feedback on proposed measure bundles in the draft DY7-8 PFM and development of any additional measures. The Clinical Champions were split into Bundle Advisory Teams in specific clinical areas to provide rounds of feedback on proposed measures for hospitals and academic health science centers. Work was also undertaken to develop measures specifically for local health departments and community

mental health centers.

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.

HHSC continued stakeholder communications in Q2 through biweekly Anchor calls and an Executive Waiver Committee meeting. On February 2, 2017, HHSC presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on proposals for DYs 7-8. On February 9th HHSC staff held a webinar on the draft DSRIP DY7-8 Program Funding and Mechanics Protocol for stakeholders.

3. Major DSRIP Activities during Federal Fiscal Quarter 3/2017 (04/01/2017-06/30/2017)

April 2017 was the first opportunity for providers to report achievement of DY6 metrics along with reporting metrics carried forward from DY5. Provider reports were due April 30, and HHS began reporting review in May and completed it in early June. Providers were sent reporting feedback in June and given until July 7 to respond to requests for additional information to support achievement of some metrics.

An additional reporting period for metrics requiring additional information (Needs More Information or NMI) to substantiate achievement opened in June and closed on July 7, 2017. Metrics approved during the NMI reporting period will be paid in January 2018, contingent on available IGT.

Following the request for an additional 21 months for the waiver in January 2017, HHS staff continued working on protocols and policies for Demonstration Years 7-8 (October 1, 2017 - September 30, 2019) during Q3. In May, HHS released a revised draft DSRIP Program and Funding Mechanics (PFM) Protocol that describes proposed requirements for DSRIP participation in DY7-8. Updates to the proposed DY7-8 PFM were made based on provider and stakeholder feedback given via an online survey as described in Q2. HHS also released a summary of stakeholder feedback and HHS responses. The draft DY7-8 program requirements are contingent on CMS approval of the PFM.

Also related to proposals for DY7-8, the work with the Clinical Champions, as described in the Q2 report, continued in Q3 with Measure Bundle topic subgroups - termed Bundle Advisory Teams - of over 100 clinicians state-wide taking part in a multi-round process to choose draft measures for each of the proposed Category C Measure Bundles. The process entailed three rounds of anonymous voting by the Bundle Advisory Teams via online surveys. Each voting round was followed by an advisory team conference call to discuss the survey results. Clinicians were

assigned to one or more Bundle Advisory Teams based on their areas of clinical expertise and interest. Bundle Advisory Team members also had the opportunity to suggest new and innovative measures. Some Clinical Champions with operational expertise were assigned to a Technical Advisory Team, which provided feedback about the feasibility of implementing suggested quality measures in a variety of settings. Community Mental Health Centers and their association provided recommendations for measures related to behavioral health, and Local Health Departments were engaged in the development of measures for those providers.

Following this work by the Clinical Champions and other stakeholders, the Draft DY7-8 Measure Bundle protocol was released in late June for stakeholder feedback, along with a draft Value Based Purchasing (VBP) Roadmap, which describes VBP efforts across HHS initiatives. Feedback on the draft Measure Bundle Protocol and VPB Roadmap was given via an online survey open to the public. A summary of provider feedback and HHS recommendations will take place in Q4 along with formal submission to CMS.

HHS continued stakeholder communications in Q3 through biweekly Anchor calls, Clinical Champions and Executive Waiver Committee meetings. On May 4, 2017, HHS staff presented to the Executive Waiver Committee updates on DSRIP and Uncompensated Care, and led a discussion on the development of measure bundles for the proposed DY7-8 Category C. On April 5, 2017, HHS staff conducted a webinar to provide technical assistance for April DY6 reporting, primarily on how to report achievement of Quantifiable Patient Impact (QPI) measures and Category 3 outcome measures. On June 20, 2017, HHS held a webinar to describe the proposed DSRIP draft protocols for DY7-8 and answered stakeholder questions.

4. Major DSRIP Activities during Federal Fiscal Quarter 4/2017 (7/01/2017 - 9/30/2017)

During Q4, HHSC reviewed the additional reporting information submitted by providers that HHSC had requested in support of achievement of metrics reported in April 2017 and approved 96 percent of these milestones/metrics. Payments for those metrics will be included in the January 2018 payment period. Based on available intergovernmental transfer funds (IGT), $781,679,377 was paid for DSRIP metrics achieved in April by July 31, 2017. A total of $10.7 billion in DY1-DY6 metrics have been paid to date.

HHSC continued working with Myers & Stauffer, LLC (MSLC), on ongoing compliance monitoring on Category 1 and 2 and Category 3 performance review. HHSC reviewed MSLC's findings and requested some additional information for some projects where providers were found to not achieve the goals or the results were not validated by MSLC. Preparations were made for the next round of reviews to begin in Q1 of FFY2018.

HHSC made changes to the Measure Bundle Protocol based on stakeholder feedback, and submitted it to CMS on July 28, 2017. The Texas Value Based Purchasing Roadmap was submitted to CMS on August 1. Based on changes to the Measure Bundle Protocol, HHSC also updated the Program Funding and Mechanics Protocol (PFM) and submitted the updated PFM to CMS on August 4. HHSC also developed proposed rules for DSRIP DY7-8 to reflect the policies outlined in the PFM protocol and the Measure Bundle Protocol. The rules were published for public comment on August 25, 2017, and are expected to be effective December 1, 2017.

HHSC developed a draft of the DY7-8 Category C measure specifications and sent them to providers for feedback and questions on September 29, 2017. There are a total of 148 unique measures for hospitals, physician practices, local health departments and community mental health centers. For hospitals and physician practices, measures are grouped in measure bundles of measures that share a common theme, apply to similar populations, and are impacted by similar activities. The specifications include details on how to report each measure. Feedback on the draft specifications was solicited via stakeholder survey during Q1 of FFY2018. HHSC also sent CMS a copy of the draft specifications.

In September, HHSC worked with providers in counties affected by Hurricane Harvey to determine how the storm impacted their ability to provide services and what difficulties they would have reporting their metric achievement during the DY6 reporting period in October. HHSC submitted a list of requests for DSRIP DY6 reporting flexibilities for providers located within FEMA designated disaster counties, and CMS sent a letter approving those accommodations on September 29, 2017. Reporting exceptions are intended to provide as much flexibility as possible to providers impacted by the hurricane while remaining within the approved DSRIP purpose and structure.

HHSC continued stakeholder communications in Q4 through responses to technical assistance requests, and biweekly Anchor calls. On August 3, 2017, HHSC staff provided the Executive Waiver Committee with updates on DSRIP and Uncompensated Care.

5. Major DSRIP Activities during Federal Fiscal Quarter 1/2018 (10/01/2017 - 12/31/2017)

Preparing for and processing October DY6 DSRIP reporting occurred in 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.

HHSC continued working with Myers & Stauffer, LLC, on ongoing compliance monitoring for

reported Category 3 and reported achievement of Category 1 and 2 metrics.

HHSC developed a template for Anchors to submit their DY6 Anchor Annual reports in December, as required by the Program Funding and Mechanics protocol. Summary information and a spreadsheet of the report responses are included in the HHSC DY6/FFY17 Annual Report submission.

Significant work continued in Q1 on negotiations with CMS on the waiver extension. HHSC staff participated in ongoing discussions with CMS staff on approval of the DY7-8 DSRIP protocols (the Program and Funding Mechanics Protocol and the Measure Bundle Protocol). On December 21, 2017, CMS approved a five-year renewal of the Texas 1115 waiver, including four years of additional funding for DSRIP, contingent on approval of the DSRIP protocols by January 21, 2018. CMS outlined five requirements for DSRIP to be negotiated for approval of the DSRIP protocols, which HHSC and CMS began discussing in Q1.

HHSC worked on development of an RHP Plan Update template for RHPs to submit their updated RHP Plans to HHSC in Q2 and Q3 (by April 30, 2018). The templates will allow providers to crosswalk their DY2-6 DSRIP projects to their system-wide activities intended to achieve outcome measures. Each provider will define their system for the purposes of DY7-8 DSRIP and report a baseline for Patient Participation by Provider (PPP). The RHP Plan Update is also the means for a provider to select their Measure Bundles or measures, depending on provider type. Anchors will combine their providers' templates into one updated RHP Plan. The Anchor RHP Plan Update template will also allow anchors to report on their RHP's updated Community Needs Assessment, their DY7-8 Learning Collaborative Plan, and their report on the required stakeholder engagement forum for feedback on the draft RHP Plan Update.

In Q1 HHSC also continued developing and refining the measure specifications for the Measure Bundles and measure lists found in the Measure Bundle Protocol. These specifications give providers detailed instructions for reporting their selected measures in DY7-8. HHSC set up a system for reviewing and responding to questions from providers about interpreting the measure specifications, which includes consultation with clinical experts.

HHSC continued stakeholder communications in Q1 through webinars, biweekly Anchor calls, and reporting companion documents. HHSC will continue to inform stakeholders of waiver developments through multiple approaches in FFY2018 Q2.

6. Major Uncompensated Care (UC) Program Activities During DY6

January 2017

- HHSC issued combined Disproportionate Share Hospital/ Uncompensated Care (DSH/UC) DY 6 applications to providers.

February 2017

- HHSC processed a 2017 DY 6 Advance UC Payment totaling approximately $1,494,673,245.

April 2017

- HHSC completed the processing of all DY 6 DSH/UC applications.
- Completed the calculation of hospital specific limits (HSLs) and verification by providers and their consultants.

May 2017

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

July 2017

- HHSC completed the processing of all DY 6 DSH/UC TXPUC applications.

August 2017

- HHSC calculated final UC payment amounts and collected IGT commitments from providers.

September 2017

- DY 6 / FFY 17 The first of two final payments is made totaling $1,041,880,769.

October 2017

- DY 6 / FFY 17 The second of two final payments is made totaling $241,536,426.

7. Summary of RHP Milestone Achievement in DY6

As required in the Program Funding and Mechanics Protocol, each Anchoring Entity submitted a DY6 Annual Report by December 15, 2017. The reports include a narrative description of the progress made, lessons learned, challenges faced, and other pertinent findings. A file of all of the DY6 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 DY6 reporting periods – April 2017 and October 2017. 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 DY7 DSRIP Payments

While HHSC's Financial Services staff will provide the official estimates of potential DSRIP payments to CMS for each quarter, based on the proposed DSRIP requirements for DY7-8, HHSC estimates that DSRIP providers will earn over $1.7 billion in DY7 DSRIP funds. Depending on the timing of CMS approval of the DSRIP protocols, the April 2018 estimates are based on only RHP Plan Update submissions while October 2018 includes Category B and D reporting, and 75 percent reporting of Category C baselines. These estimates do not include DY6 metrics carried forward into DY7 or the Anchor one-time DY6 payments, so the total payment amounts for July 2018 (based on April 2018 reporting) and January 2019 (based on October 2018 reporting) likely will be higher that what is reflected below.

RHP	DSRIP Allocation DY7	Estimated April 2018 Reporting	Estimated October 2018 Reporting
RHP 1	$118,240,872	$23,648,174	$41,753,808
RHP 2	$111,593,791	$22,318,758	$39,406,558
RHP 3	$639,323,692	$127,864,738	$225,761,179
RHP 4	$142,617,471	$28,523,494	$50,361,795
RHP 5	$197,621,488	$39,524,298	$69,785,088
RHP 6	$341,563,637	$68,312,727	$120,614,659
RHP 7	$175,775,070	$35,155,014	$62,070,571
RHP 8	$50,257,477	$10,051,495	$17,747,172
RHP 9	$474,659,140	$94,931,828	$167,614,009
RHP 10	$301,583,772	$60,316,754	$106,496,769
RHP 11	$37,073,614	$7,414,723	$13,091,620
RHP 12	$119,392,884	$23,878,577	$42,160,612
RHP 13	$21,007,292	$4,201,458	$7,418,200
RHP 14	$73,447,394	$14,689,479	$25,936,111
RHP 15	$142,853,115	$28,570,623	$50,445,006
RHP 16	$39,186,072	$7,837,214	$13,837,582

RHP 17	$35,300,965	$7,060,193	$12,465,653
RHP 18	$23,147,377	$4,629,475	$8,173,917
RHP 19	$29,741,440	$5,948,288	$10,502,446
RHP 20	$25,613,437	$5,122,687	$9,044,745
Total	$3,100,000,000	$620,000,000	$1,094,687,500

B. POLICY, ADMINISTRATIVE AND FINANCIAL DIFFICULTIES

The Texas DSRIP program continued to evolve during DY6, as HHSC, CMS, RHP anchors, and DSRIP providers implemented this large and diverse program during a transition year. Key challenges have been developing program policies for further demonstration years 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 (17Q1-18Q1). The attachment includes annual and quarterly Dental, STAR and STAR+PLUS enrollment summaries.

Attachments C1-C3 – Provider Network and Methodology. The attachments summarize STAR, STAR Kids, 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, STAR Kids, and STAR+PLUS out-of-network utilization.

Attachment E – Distance and Travel Time Standards. The attachment shows the State's distance and travel time standards by provider type and county designation.

Attachment H1-H5 – Network Access Analysis. The attachments includes the results of the State's analysis for PCPs, main dentists, and specialists.

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

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, STAR Kids, and STAR+PLUS complaints and appeals received by plans.

Attachment O – Complaints to HHSC. The attachment includes information concerning Dental, STAR, STAR Kids, 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 (2017 SFQ4). The attachment represents total MSHCN enrollment in STAR, STAR Kids, 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 Kids, STAR+PLUS, and Dental Program plans sent to the OIG during the biannual reporting period.

Attachments V1-V3 – Claims Summary (2017 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 6 DSRIP reporting by RHP and annual reports from all anchors

Attachment X - DSRIP Project Summary October DY6. 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 2017.

Attachment Y- Remaining DSRIP Payments. Reported biannually after DSRIP payments are distributed.

STATE CONTACTS

For questions regarding the waiver, please contact:

Natoshia Petsch
Waiver Specialist, Policy Development Support
Texas Health and Human Service Commission
4900 N Lamar, MC-H600
Austin, TX 78751
(512) 487-3307
Fax (512) 730-7472
Natoshia.petsch@hhsc.state.tx.us

Kathi Montalbano
Manager, Policy Development Support
Texas Health and Human Service Commission
4900 N Lamar MC-H600
Austin, Texas 78751
(512) 730-7409
Fax (512) 730-7472
Kathi.montalbano@hhsc.state.tx.us

Date Submitted to CMS: May 24, 2018

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
MCCO	Managed Care Compliance & Operations (Formally 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